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ANNUAL MEETING, ATLANTIC CITY, APRIL 30, MAY 1 and 2

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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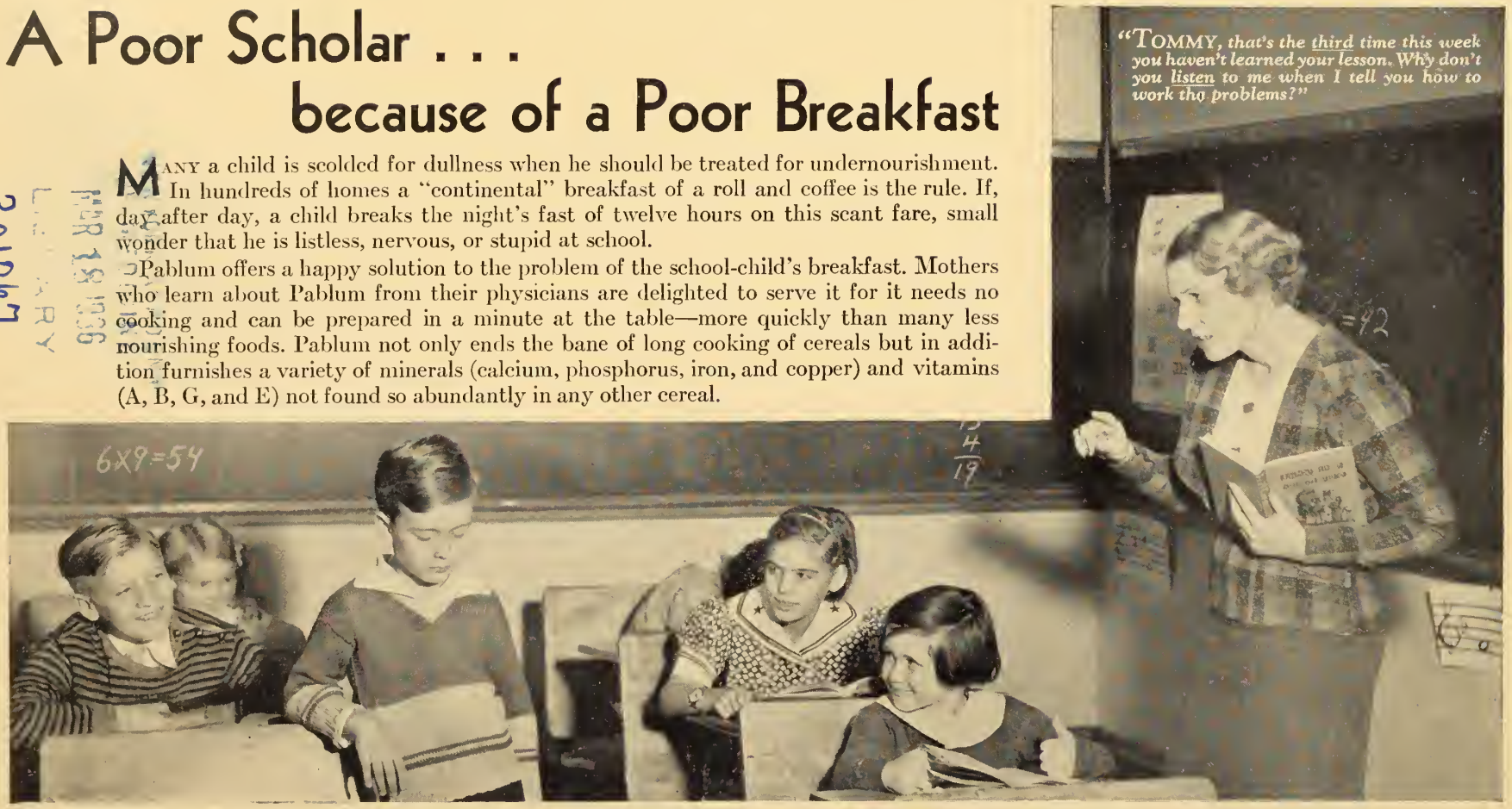
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Volume XXXII.
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Under the
Direction of the
Committee on Publication



Editor of
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Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

New Year Greetings

The new year of the calendar coming in the middle of the year of administration, offers an opportunity to estimate the growth of the activities of The Medical Society of New Jersey.

The program of the last six months has been in development rather than innovation; and in the unfolding of time-honored methods rather than in the introduction of new projects. Your President has had the hearty coöperation of the officers and committeemen, whose large number justifies the descriptive title "a state society at work". Those whose names appear in The Journal number 175. each group being assigned to a specific function. Fortunate indeed is the President who can count on the assistance of so large a number of earnest workers on his personal staff.

Equal credit for coöperation and originality belongs to the officers and committeemen of the county societies, each of whom is in reality a member of the staff of the State Society, ready to promote its projects in the local communities.

A pleasing atmosphere of harmony and cooperation exists throughout the personnel of the County Societies and the State organization. With such a helpful spirit our work is bound to be successful. In all our activities progress is plainly evident; and at this halfway point of our year we may anticipate marked accomplishments to be reported to you at the Annual Meeting.

The official leaders of the State Society are successful to just the degree that they interpret the aspirations and needs of the individual members. The State officers and committeemen are among the most active of the members of their county societies, and are more interested than ever in the medical services of their home communities.

To every member your President extends his hearty New Year Greetings and wishes for each of you *health* for yourself, *wealth* of your spirits, and *happiness* which comes from work conscientiously done.

Lancelot Ely,
President.

Annual Meeting

The 169th Annual Meeting of The Medical Society of New Jersey will be held on April 30 and May 1 and 2, 1935, in Haddon Hall, Atlantic City. The early date is necessary on account of the meetings of the American Medical Association (June 10-14), the Canadian Medical Association, and several national organizations of specialists which will be held in Atlantic City during May and June. The earlier date will not only enable the State Society to obtain adequate accommodations but will also allow its members time to arrange their work so that they may attend both series of meetings. Experience has shown that the attendance at the State meeting is not noticeably diminished by the A. M. A. meeting when the two are held a month apart.

The preparations for the Annual Meeting are already under way, particularly those for the scientific sessions, and the House of Delegates. The scientific program will be arranged by the Standing Committee on Scientific Work of three persons, whose major duty will be to secure speakers of outstanding ability in the practice of medicine. Last year the program carried the names of forty-seven speakers and thirty-five discussors of papers—a total of eighty-two formally listed as participants. It will, therefore, be seen that the committee and the chairmen of the scientific sections are entrusted with responsibilities of a most exacting character.

The preparations for the meeting of the House of Delegates, in contrast with those for the scientific program, require the participation of every member, beginning with the election of the members of the House by the County Societies. A grave responsibility therefore rests upon every member of every County Society to choose delegates who have had wide experience in the activities of their respective societies and are students of the problems which now confront all practitioners of medicine.

A most important item in the plans for the meeting of the House of Delegates is the preparation of the annual reports by the officers and the several committees. Last year the reports of twenty-seven officers and committees were presented before the House.

A feature introduced last year was the publication of the reports in the May Journal, one month in advance of the Annual Meeting. The department of Original Articles, consisting of 40 pages, was given over to those reports. Four great advantages of this feature were evident:

1. Hours of time which were formerly devoted to the reading of the reports at the meeting were saved, because every member had a copy of the printed reports in his hands.

2. The members came to the meeting with the contents of the reports well considered and were prepared to take intelligent action on their recommendations.

3. Reference committees, to whom the reports had been referred, were prepared to give hearings to every member who had criticisms or suggestions to make, thereby giving every member unlimited opportunity to express his opinion.

4. The members had the benefit of the judgment of the reference committees on the recommendations contained in the reports.

The execution of this plan justified the expectations of those who planned the meetings. Every moment of the meeting was interesting, and all the members gave respectful attention to the proceedings. Moreover, the sessions opened and closed *on time,* with a full attendance.

This plan will be followed this year. The reports will be prepared in time for their publication in the April Journal, which will be scheduled to be in the hands of every member of the Society three weeks in advance of the meeting.

Preparations are also under way to make all the other features of the Annual Meeting of unusual interest and profit, in keeping with the reputation of The Medical Society of New Jersey for its high standard of ideals, its efficient methods, and its practical accomplishments.

Lancelot Ely,

President.

Preserve Your Journals

The project of supplying a box to hold the twelve Journals of the year has been described in the Journals of August, October, and November, and was approved by the Conference of the County Secretaries and Reporters. These officers have frequent occasions to refer to past numbers of The Journal, and realize the conveniences and necessity of keeping The Journals together on their desk, or bookshelves, where they are readily accessible for reference.

The greatly expanded field of the medical societies makes their activities of direct interest to every practicing physician in New Jersey. The Journal is the general repository of the records of current events and developments, with cross references, indexes, and explanatory comments which make the records available for easy consultation. The value of the records is not only immediate and current, but it is also perennial to the individual member, and to every officer.

The Trustees have approved the plan of supplying neat boxes, as shown in the illustration, to the members at a charge of thirty cents apiece, in order to cover the cost of their manufacture and distribution. The boxes will be distributed through the Secretaries of the County Societies, who will take the orders of the members. Samples will soon be available for exhibition at the meetings of the County Societies.



Many members will wish to bind their Journals at the end of the year. This service may be available through the Executive Offices of the State Society.

The Index of the 1934 Journal

The twelve monthly issues of The Journal of The Medical Society of New Jersey of 1934 are indexed in the December issue with two objectives in view:

1. To reveal the scope and extent of the activities that are recorded.

2. To make the reports available for ready reference.

It is comparatively easy to secure reports of the activities of the State Society and its officers and committees, but it is far more difficult to secure complete reports of the activities of its twenty-one component county societies. The test of the efficiency of the State Society is the response of the county societies to the suggestions of its officers and committees. It is not sufficient that the State Society should pass resolutions. The plan of action of the Medical Society of New Jersey is unique among the medical societies of the several states in that it follows up those resolutions and endeavors to inspire the county societies to respond to them. An editorial in the May Journal, page 263, states:

"It is the sum of the attitudes of the county societies that make up the policy of the State Society. A full index of the county society activities reported to The Journal may be expected at the end of the year, when every reporter may see the evidence of the appreciation of his work."

The annual report of the Publication Committee on page 272 of the May number contains the following statement:

"Only those who deal constantly with records and precedents can appreciate the full value of complete reports and records available in an accessible form. All the items of activities recorded in The Journal will be fully indexed and issued as an integral part of the December Journal."

A sincere attempt has been made to carry out these plans in the annual index, especially that part devoted to the reports of the *County Societies,* which occupy more space than that of any other department of The Journal. Two reasons may be assigned for the completeness of the County Society reports:

1. The broadened scope of their activities.
2. The experience of the reporters, many of whom have served for a decade or more.

The plan to index the reports of the county societies seems to have been first suggested in 1925 by Dr. Flora Adams, reporter for Bergen County, whose obituary appeared in the November, 1934, Journal, page 665. (See Transactions 1925, page 6.) It is hoped that the adoption of the suggestion made by Dr. Adams a decade ago will encourage the reporters to prepare their reports with a completeness that shall insure the county societies that recognition to which they are justly entitled.

Landmarks of Medical Practice

The present system of medical practice has developed slowly and gradually. Every medical discovery has raised the level of the common reservoir of scientific knowledge until its accumulated store of information and experience flows spontaneously to every practitioner who establishes channels of connection with it. Every rise in the level of medical knowledge extends its practice into new fields whose boundaries are indicated by prominent *landmarks of practice.*

BEGINNINGS OF MEDICAL ORGANIZATION

The first great landmark of medical practice in New Jersey was the founding of the State Medical Society on July 23, 1766. The object of the new organization was to establish and maintain the essential principle that every physician should be prepared to give medical service according to the highest standard of medical knowledge of the period. That standard has been raised periodically to conform to the rapid advance in medical knowledge, and its maintenance is still the dominant object of the medical profession. Every medical society today is a center of graduate education, and the presentation of scientific papers is still the major feature of every medical society meeting, just as it was in 1766 when The Medical Society of New Jersey was founded.

MAN-MADE CAUSES OF SICKNESS

The second great landmark in medical practice was the establishment of the State Board of Health in 1877, following the recognition of man himself as a dominant cause of unhealthful conditions which had been ascribed to states of nature. During a whole century an essential item on the program of every meeting of The Medical Society of New Jersey had been a report from each county on its prevailing forms of sickness and speculations on their relation to gross conditions of the earth, air, fire, and water, as indicated principally by the soil and the weather. The objective of the Board of Health was the community control of the man-made conditions which rendered the natural elements unhealthful. The medical profession was slow in recognizing its essential duty of leadership in the great movement for the prevention of pollution of the earth, the air, and the water supplies; but physicians gave their recognition when the science of bacteriology, born during the decade of the eighties, made possible the detection of pollution by scientific tests which only trained physicians were capable of applying.

The way of the physician was hard when he faced the opposition of the people to the imposition of tests and regulations which they but dimly understood. Older physicians still in practice recall the opposition aroused by

their support of the Health Department in its alleged interference with the inherent freedom of the American people to do as they pleased. Physicians had to endure the lot of all conscientious pioneers in arousing public sentiment to uphold them in their attempts at the health control of *well* people.

THE RISE OF LAY HEALTH ORGANIZATIONS

The third great landmark of medcial progress was the rise of lay health organizations beginning in the early years of the present century and culminating in the endowment of great Health Foundations whose objectives were two-fold:

1. To arouse the *people* to do their part in health protection.
2. To provide the financial means of conducting *"demonstrations"* of the efficacy of the measures proposed by Health Departments.

The leadership of lay health organizations in popular health movements was a great factor in inspiring whole communities to support their Departments of Health in protecting the people against disease, often against their will.

LEADERSHIP OF THE MEDICAL PROFESSION

We are now in the midst of the establishment of the fourth great landmark in medical practice through the action of medical societies in assuming the leadership in all health movements, especially those of medical administration. The great health foundations and lay societies had accomplished their objectives largely by the astute method of asking the governing board of a city or village or hospital for permission to conduct a free "demonstration" with the expectation that the Board would assume its cost and direction when its value had been shown. The idea of getting something for nothing has made a strong appeal to governmental officials, and through it the "foundations" have gradually acquired an influence in medical administration greater than that of the medical profession.

There is a specific field of action for the lay health organizations, and another for the medical societies. The need of the hour is that the two groups enter into agreements along two main lines:

1. The assignment of a specific field of action to each organization.
2. The active cultivation of its own field by each group.

The lay organizations will undoubtedly cultivate their own fields with great zeal, and will initiate legislation leading to governmental control of the distribution of medical services to about one-half of the people of the United States. The great work of the medical societies will be to devise a practical system for the distribution of medical services that will take the place of the revolutionary proposals of the lay workers. The only effective way to prevent the adoption of socialized medicine will be to suggest a better plan.

THE PRESENT PROBLEM

Physicians were not greatly concerned when the lay foundations confined their efforts to demonstrations in isolated communities scattered here and there throughout the land; but the medical profession became alarmed when the lay organizations began to exert their influence in state legislatures and the national congress, without conferring intimately with the doctors. The present condition is a crisis that is acute even though it has long been expected.

Every landmark of medical practice has been a crisis which has required radical changes in habits of medical thought and in methods of practice. Physicians have met each past crisis by the adaptation of the older forms of medical service to the modern needs and conditions of the people. The physicians of New Jersey will meet the present emergency in the same spirit.

Promoting the Public Health Hour

When the project of the *Public Health Hour* of The Medical Society of New Jersey is discussed, some degree of disappointment with its results is often heard. The project does not develop spontaneously, but its growth depends on its coördinated nurture by physicians, public health organizations, and parents of children.

The project has the very definite objective of providing the means by which immunizations against diphtheria and smallpox may be available in the private offices of physicians instead of public clinics. About one thousand physicians have given their written assurance of coöperation in the administration of the diphtheria toxoid and the smallpox vaccine; and the State Department of Health furnishes the immunizing material free. Physicians and departments of health are prepared to do their parts in immunizing children.

At a meeting of one county medical society the announcement was made that a large proportion of the members were keeping their offices open for the Public Health Hour, but that few patients were seeking the immunizations. The methods of the *production* of the services of immunization are excellent and efficient; but methods of *salesmanship* must be improved and extended before the people will flock to the doctors' offices in any considerable numbers.

Three methods of salesmanship are open to physicians in promoting the Public Health Hour:

1. The personal offers of service by the doctor.

2. The solicitation of agents, such as Parent-Teachers Associations and public health nurses.

3. Informative items in the newspapers.

The mere mention of any one of these methods by a physician a quarter of a century ago would have precipitated his expulsion from his county medical society; but today they are considered to be entirely proper and ethical.

1. The strongest appeal will be that made by the physician himself directly to those patients to whom he is the family doctor. It is his duty to supply all *preventive* as well as *curative* services; and to offer new forms of services as they are developed. The Morris County Medical Society has approved the following form of letter which is adapted from that of the Essex County Medical Society:

Dear Mrs. ———:

Has (Mary) been immunized against diphtheria or vaccinated against smallpox? You no doubt know that diphtheria, like smallpox, is now a preventable disease.

The New Jersey State Medical Society is conducting a state-wide campaign and the Morris County Medical Society is anxious to see every child over six months of age in this County successfully immunized against diphtheria. Coöperation of the parents is essential if we are to achieve our aim to eradicate this disease. It is in this spirit that I, as your family physician, address this letter to you.

I suggest that you call at my office on ———, the ——— of ———.

(Signed) ———, M.D.

2. The promotion of immunizations is a major object of lay groups of health workers such as Parent-Teachers Associations and public health nurses. These organizations have usually adopted the mass method of the public clinic, but they will be ready to direct children to the private office of the family physician in his Public Health Hour as soon as county medical societies make the proper approach to them.

3. The editors of local newspapers consider public health items to be "live" news; and are always ready to promote every movement for the benefit of children. The appeal of a movement is derived largely from its promotor; and no group has more influence than the physicians. The editor always wishes to inject personal appeal into his story, and to quote a prominent leader of a movement. The president or secretary of a County Medical Society or the chairman of the Public Health Committee must therefore be willing to be quoted over the title of his position.

The active application of these three methods by physicians is essential in securing prompt results from the Public Health Hour.

ORIGINAL ARTICLES

OSTEOGENIC TUMORS

By John D. Tidaback, M.D., Summit, N. J.,
and
Attilio Galasso, M.D., Morristown, N. J.

Read before the Section on Radiology at the Annual Meeting of the Medical Society of New Jersey on June 7, 1934, in Atlantic City

Osteogenic tumors as commonly known are tumors arising from bone. The accepted definition, however, designates that an osteogenic tumor is a tumor which arises from the ancestors of cells which, when differentiated, have the power to develop into myxomatous, cartilaginous, or osseous tissue.

It is apparent that, if the power of the cellular structure to form osseous tissue in repair of fracture, which is a physiological function, that power lies latent at all times in the bone-forming tissues; and when from any cause the normal restraint and equilibrium is destroyed, these latent potential bone-forming cells begin to function in the process of forming new bone.

In their process of development, the growing cells may develop into one of three forms of tissue:

1. Myxomatous, forming *myxomas;*
2. Cartilaginous, forming *chondromas;* or,
3. Osseous, forming *osteomas.*

When the physiological restraint of these cells is removed, they have a tendency to develop rapidly, leaning more toward the embryological state. If physiological restraint is established, these cells may become stable at any stage of their differentiation. If, however, physiological restraint is not established, the cells will become unstable and will run wild, passing from the benign to the malignant.

If these unrestrained cells separate and enter the lymphatic or blood stream, they may set up foci at other sites in the body.

It is also apparent from the study of these tumors that in the cellular elements involved, one or all of the stages of cellular differentiation may be observed, so that it is not always easy or practical to designate the type of tumor from the cellular structure alone. Nevertheless, the knowledge obtained that a particular stage of differentiation is predominant is a great aid in determining the type of tumor.

It is well to bear in mind that many of these tumors develop in the years when the cellular structure is most active during the growth of the body, and when the physiological restraint is changing from an unstable to a stable bony structure.

THE OSTEOMAS

Osteomas should be restricted to tumors of bone and differentiated from the *exostoses.* Histological study fails to differentiate simple hyperplastic growth of bone from the true osteomas. Both processes show the surrounding of the growth by osteoblasts which add to the tumor substance; and, the production of dense lamillated bone with few Haversiancanals or spongy areas. The gross and clinical features seem to form the best criteria for the differentiation of the true osteomas from hyperostosis.



Fig. 1.—X-Ray of Osteochondroma

The osteomas are commonly found in the skull and jaws. They apparently arise from the cortex and grow very slowly, producing new bone. They do not destroy bone or invade

the tissues. They may be found either single or multiple, and occur about the second decade. They do not metastasize and are considered benign.

EXOSTOSES

The exostoses or osteochondromas are the most common of osteogenic tumors. They occur during the second and third decades of life. Situated near the ends of long bones near the attachments of muscles and tendons they give the impression that the cause of their growth is a congenital weakness in the physiological restraint at these points. It is noted that they arise from the cortex of the bone and grow slowly, not invading the tissues but pushing them aside. They may have either a broad base or be attached by a pedicle. They usually have a visible cartilaginous cap. They do not destroy or expand the bone; do not metastasize; and, are considered benign.

The pathological aspect shows the junction of both tissues as two constricting margins. The rounded and light eosinophillic or tumor margin is overlaid with loose connective tissue which is a fibrous or hyalinized state. The tissue dips down at places showing proliferation and organization into lobules. The proliferating points are either cartilaginous or preosseous tissue. The cartilage rapidly assumes the adult form and undergoes calcification. Both the cartilage and the bone thus newly formed are of normal benign adult type. Occasionally these tumors may undergo malignant change and it is either the precartilaginous or preosseous tissue which is responsible for the malignancy.

BONE CYSTS

Bone cysts arise from the medulla and may be either single or multiple. They occur during the first and second decades of life; are found near the ends of long bones; grow very slowly; do not metastasize; and, are considered benign.

The pathological aspect of a bone cyst shows a loose fibrous tissue with scattered spicules of bone away from the cyst. As one approaches the cavity formation the fibrous tissue becomes more cellular, simulating a low-grade spindle cell sarcoma. Near the cyst it shows hemorrhage and giant cells of the epulis type. New bone spicules, cellular fibrous tissue, giant cells and the preosseous edema are the typical findings in osteitis fibrosa or the healing reaction around the bone cyst.

GIANT CELL TUMORS

A giant cell tumor is shown in Figure 2. Note that it involves the epiphysis and extends into the shaft. There is expansion and thinning of the cortex with trabeculae.



Fig. 2.—X-Ray of a Giant Cell Tumor

These tumors arise from the medulla in the epiphysis during the second decade. They are usually asymmetrical in position; grow very slowly; do not metastasize; and, are considered benign.

The outstanding pathological features of giant cell tumor are the large multinucleated giant cells averaging over 25 nuclei to the cell —over 50 to the lower power field. There may be increase in the fibrous tissue at places where calcification is apt to occur. A tumor of this type may recur. Many pathologists consider this a stage of osteitis fibroso cystica.

MALIGNANT TUMORS

In the study of the malignant osteogenic tumors it is noted that it is very difficult to differentiate between the medullary, cortical, and the periosteal forms. In fact, when they are observed they appear to be a mixture of two or all three types.

The malignant osteogenic tumors, whether arising from the cortex, medulla, or periosteum, have many things in common. They

usually occur during the first and second decade of life; found near the ends of long bones; grow very rapidly; invade the tissues; and, metastasize early.

The roentgenological aspect of the chondromyxosarcoma is shown in Figure 3.

There is noted the general characteristics of giant cell tumor of the lower end of the humerus but above the epiphyseal line. There is the asymmetrical expansion with trabeculae and destruction of the cortex.



Fig. 3.—X-Ray of a Chondromyxoma

Chondromyxsarcoma in the gross shows material of the consistency of cartilage. There are areas of myxomatous tissue, imperfectly formed cartilage, and fibrous tissue which



Fig. 4.—Osteogenic Tumor

blends with the previously mentioned ones. There are portions in the section which resemble the epulis where the stroma is made up of short spindle cells suggesting malignant character.

Figure 4 shows a photograph of an osteogenic tumor in a man 67 years of age following an injury a year and a half ago. The tumor presents a large mass on the outer side of the knee joint with skin lesions on the anterior aspect of the upper leg.

The roentgen examination reveals a large tumor on the outer side of the right knee apparently not connected with the bone or periosteum. Within the tumor mass there is noted bone production in the center of the tumor tissue. The following is the pathological report:

The gross tissue submitted appears about four and a half inches in diameter and three inches in depth. It consists of superficial layer of skin underneath which there was hemorrhagic and necrotic material which extended several inches beneath the surface. In the center of the mass was apparently bone. The lowermost layer was made up, of approximately one and a half inches of cartilaginous base.

The microscopical sections reveal presnece of marked anaplastic type of sarcoma. The presence of malignant cells of varying size, many mitoses, and malignant giant cells containing about 10 to 15 nuclei, some in mitosis with invasion of the various parts of the section including the skin point to marked malignancy. There can be seen decalcified bone, cartilage, and immature forms whose nuclei are also large and rich in chromatin, and some areas where the tissue appears myxomatous—in other words there is present the various types of tissue in bone histogenesis.

Many of the cells are large and spindle in type. This tumor indicates osteogenic sarcoma (capsular) or osteogenic sarcoma from degeneration of osteochondroma.

The roentgenogram of the chest revealed throughout both lung fields rounded masses of increased density of irregular size with smooth borders.

We describe another osteogenic tumor which occurred in the second decade. It is situated in the upper end of the tibia involving the medulla, cortex, and the periosteum with invasion into the soft tissues. With this invasion there is noted destruction of the cortex with lipping of the periosteum. There is also the

typical "sun ray" spicules of bone growing at right angles to the shaft.

The histological specimen on this case presented a very cellular and active type of growth as indicated by as many as three mitoses per high power field, irregularity in the size of the nuclei, and malignant giant cells containing about six to ten nuclei in mitotic stages. At autopsy the whole right lung and left tracheobronchial node showed cells with the same characteristics. There was also found in the right lung a piece of bone one and a half cms. in diameter which proved to have been formed by cells which had metastasized.

Chart 1 shows some of the osteogenic tumors and gives some interesting information which will aid in the differentiation of the benign and the malignant tumors.

The benign tumors may show production or absorption of bone; they do not invade the tissues; they occur about the same age period; are of slow growth; and, do not metastasize.

The malignant tumors show production and destruction of bone; they invade the tissues; they occur about the same age period; grow very rapidly; and, metastasize.

Chart 2 shows the pathological features of osteogenic tumors.

The diagnosis of osteogenic tumor is based on the careful study of the history, present symptoms, physical signs, biopsy; and roentgen ray.

CHART 1

OSTEOGENIC TUMORS

		Origin	Bone	Cortex	Inv.	Single	Period	Growth	Site	Met.
Benign	Osteoma	Cortex	Prod.		No	Yes	2	Slow	End	No
	Osteochondroma	Cortex	Prod.		No	Yes	1–2–3	Slow	End	No
	Bone cyst	Medulla	Prod.?	Expan.	No	Yes	1–2	Slow	End	No
	G. C. tumor	Medulla	Prod.?	Expan.	No	Yes	2	Slow	End	No
Malignant	Primary chondro-myxosarcoma	Cortex Periosteal	Prod. Dest.	Dest.	Yes	Yes	2–3	Rapid	End	Yes
	Secondary chondro-myxosarcoma	Cortex Periosteal	Prod. Dest.	Dest.	Yes	Yes	3	Rapid	End	Yes
	Chondroblastic sarcoma	Cortex Periosteal	Dest.	Dest.	Yes	Yes	2–3	Rapid	End	Yes
	Osteolytic ostergenic sarcoma	Cortex Medulla	Dest.	Dest.	Yes	Yes	1–2+	Rapid	End	Yes
	Periosteal sarcoma	Cortex	Dest.	Dest.	Yes	Yes	1–2	Rapid	End	Yes
	Osteogenic sarcoma	Cortex	Dest.	Dest.	Yes	Yes	1–2	Rapid	End	Yes
	Medullary sarcoma	Medulla	Dest.	Dest.	Yes	Yes	2	Rapid	End	Yes

CHART 2

OSTEOGENIC TUMORS

	Bone Formation	Cartilage Formation	C. T.	Malignancy	G. C.
Osteoma	Yes. Spontaneous or traumatic. Not inflammatory in origin.	Derived from cartilage. Yes.	Osteo-blasts.	No	No
Osteochondroma	Yes. Adult. Normal.	Yes. Rapidly assumes adult form	Fibrous, hyalinized pre-cart-osseous lob. prolif.	No	No
Bone cyst	Yes. New bone spicules with many fibroblasts and osteo-blasts.	No. Almost low-grade spindle sarcoma. Fibrous. Diffuse pre-osseous edema.		No	Epulis type
Giant cell tumor	May occur	No cartilage. Fibrous tissue.		May recur	Yes. 25 N 50 l. pf

CHART 2—Continued

OSTEOGENIC TUMORS

	Bone Formation	Cartilage Formation	C. T.	Malignanc.	G. C.
Primary chondro-myxosarcoma	No. Both the primary and secondary forms show areas of imperfectly formed cartilage and myxomatous tissue. One also notes short spindle cells in the stroma which seem active.			Yes	Epulis type
Secondary chondro-myxosarcoma	Rate of growth is rapid as a rule.				
Chondroblastic sarcoma	No true bone	Early chondroblastic cartilage abortively calcified and resorbed.		Yes	Yest
Osteogenic-lytic sarcoma	Yes. Osteolytic.	Occurs in cancellous bone? Very anaplastic and invasive.			Epulis and Mal. type
Periosteal	Yes. Immature bone cart. and osteoid tissue. Cells are hyperchromatic spindle rounded or polyhedral. They are rather fibrous and hard.			Yes	with 2-10 N.
Osteogenic	Yes. There is found embryonic cart. with atypical calcif. and ossif. Myxomatous tissue. Few trabeculae, many osteoblasts. Hemorrhage. Malignant. Many mitoses per H. P. F.				Yes Mal. type
Medullary	Similar to other types. Malignancy in all varies directly with anaplasia.				

THE MEDICAL SOCIETY OF NEW JERSEY EXPERIMENTS IN FURNISHING COMMUNITY HEALTH SERVICES

LEROY A. WILKES, M.D.,
Executive Secretary, The Medical Society of New Jersey

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Progressive physicians experiment almost continuously to improve their service to their patients. Why shouldn't progressive Medical Societies experiment? The Medical Society of New Jersey has made a beginning.

Worthwhile experiments are founded upon scientific principles, and are developed largely through practical trial and error. Medical practice has *always* been improved as a result of such experiments, and patients individually have benefited therefrom. *Modern* medical practice has resulted from the exchange, in medical societies, of the knowledge and experience gained in experiments, conducted and reported by the individual members; and in no country is a better medical service now provided than in the United States.

DUAL ROLE OF THE PHYSICIAN

The Medical Society of New Jersey emphasizes the *dual* responsibility of the physician, first, to his private patients, and secondly to those in the community unable to afford private medical service. To provide for the latter group, physicians have, as individuals, always given their services free in charity hospitals and clinics. In New Jersey the physician is, in the projects now under way, the delegated representative of organized medicine—as represented by his medical society.

Industry and the cultists do not attempt to provide for the indigent, but they do offer services for pay, in active competition with the private physician. Certain lay groups, perhaps unconsciously, encourage the abuse of the free service offered by physicians for the indigent only. A considerable number of medical men are wondering whether, under modern conditions, private physicians are *now* obligated to provide free services to anyone, except in emergencies. Is it not claimed, under our *New Deal* in Government, that it is the obligation of the *Community* to provide for indigents out of the taxes collected; and should

not the non-indigent who seeks free medical service relieve the generally overburdening tax load by supporting himself in sickness and in health? The Medical Society of New Jersey is experimenting to provide certain preventive services at low cost *in cases where the community as a whole will benefit.*

Because of the *abuse* of the free services provided by individual physicians for indigents, efforts are now being made by the New Jersey Medical Society to determine why, and how, such abuses occur, and what might be done to minimize them and to help restore morale, justice, and fair play. What medical services are "essential", and how can the profession best supply them? In New Jersey we have begun in a small way to experiment with two specific services. The procedure in setting up these experiments in the Medical Society is now quite established.

A COMMUNITY MEDICAL SERVICE PROJECT

The essential features of a community medical service project are:

1. An organized effort on the part of the Medical Society to furnish certain services to the community through its members, each acting as a delegated representative of organized medicine.

2. Members who respond to requests to furnish medical service in a coöperative program with other community agencies, but *only* when the Medical Society is formally invited to help in the planning, and later to participate in the work.

3. All policies, programs, and agreements affecting *medical services* should be drawn by the State Medical Society if the project is *state-wide* in its activities. The *ways and means* must be adapted to local conditions and needs. If the activities are confined to the County, the County Medical Society will in a similar way, act for the medical profession.

4. Coördination of medical services rendered by individuals in *all* state-wide programs is to be effected by the officers and committee members of the State and County Societies, through the executive officers in the State Medical Society offices in Trenton.

5. All medical services in coöperative community projects are to be paid for, *unless all other* coöperating personnel serve without remuneration.

6. Family physicians are the unit which must provide sound *preventive*, as well as sound *curative* medical services, to the "ultimate consumer".

PROJECTS NOW IN OPERATION IN NEW JERSEY

Two projects were selected as a beginning. When their practicability is demonstrated, further experiments will be conducted.

Originality is not claimed for the idea of physicians coöperating in community projects, for this has been carried on by physicians for many years. The Medical Society of New Jersey is pioneering in having its members definitely *organized* under a plan which furnishes in each physician's office, or in the home of the patient, medical service of limited scope through members in the component societies. The Medical Society of New Jersey has not yet departed from the principle of free service to the traditional indigent, for whom the community has *as yet* not provided.

The *two projects* now in operation and sponsored by the Medical Society of New Jersey are:

1. *The Medical Relief Project,* in which medical relief is given to acutely indigent persons who are approved by the Emergency Relief Administrators in their own county, at agreed-upon reduced fees.

2. *The Public Health Hour Project,* in which immunization of children against diphtheria and vaccination against smallpox at a reduced fee in the early years of life when the morbidity and mortality is highest. This is free to indigents.

MEDICAL RELIEF FOR INDIGENTS

The medical relief program was developed, and mutually agreed upon in accord with approved principles accepted as a basis for cooperation with the State Emergency Relief Administration. Medical services are provided in the physician's office, and in the home when necessary, at reduced rates, and are paid for out of emergency funds provided by governmental agencies through taxation. Payments

are made (by the Emergency Relief Administration) upon presentation of bills approved by the supervising committee of the County Medical Society as reasonable and just, under the mutual agreement.

The *supervision* of the medical services rendered, and the *discipline* of the physicians remains in the hands of the *medical profession.* The *selection* of the patients, and the *payments* made for services rendered are entirely in the hands of the Emergency Relief Administration Executives.

Provision is made for "emergencies", and for a limited amount of services of a highly specialized character, though the great bulk of the services are intended to be those ordinarily provided by the family physician.

The plan thus limited in scope is only intended for the duration of the emergency; and equally important is the qualification that the agreement shall be in effect only as long as there is mutual confidence between the contracting parties. Either of the coöperating groups may terminate the agreement *for cause,* upon due notice.

"THE PUBLIC HEALTH HOUR"

This project aims to protect children early in life against those communicable diseases selected, when such preventive measures are most needed. The plan provides widespread distribution of specific services at a cost which the people can afford to pay. These services are, however, furnished free to the indigent. The State Department of Health provides the biological products used, and the program is conducted in accord with plans mutually agreed upon in coöperation with the State Department of Health.

THE PLAN IN OPERATION

In addition to services offered in the regular office hours of the physician—in which his usual charges prevail—each participating physician sets apart in his office a special "Public Health Hour", in which no "appointments" are made, but "first come, first served" is the rule. It is similar to the public immunization clinics, but is privately conducted in the physician's own office. The scope of the service rendered is limited to immunization and vaccination. The cost is made uniform throughout the State at one dollar per visit, with free service for the worthy indigent.

No claim is made that this service is the equivalent of the more complete service given by the physician in his regular office hours.

The scope of service in the "Public Health Hour" is *strictly limited* to preventive measures, but within its scope the service is unquestionably as effective as that given elsewhere.

EXPANSION CONTEMPLATED LATER ON

Many additional services are contemplated for inclusion in the scope of the "Public Health Hour", at a later date; but the chief virtues of the experimental efforts now being put forth by the Medical Society are: limited scope of program, definite aims, clear objectives, organized plans, and supervised effort. We are experimenting unofficially with a preschool child examination record which the child will take to school when he enters. This record provides the school with more complete and more reliable data than a mere school medical inspection can provide, and sends the child to school fit to benefit most from the educational opportunity provided there.

MEDICAL LEADERSHIP

Organized effort requires able leadership. In the medical profession are many potential leaders who only need to be given the opportunity to show their ability and willingness to help in any movement sponsored by their profession—especially in their own society. We have such leaders in New Jersey and we placed them in charge of the planning of the program. Others were quickly found to carry on assigned parts of the program in which their knowledge of local needs and conditions make them most valuable in integrating and modifying the state-wide project with least friction and loss of efficiency locally.

ADVANTAGES OF NEW JERSEY

New Jersey has a great advantage in the fact that the transportation facilities and the size of the State make it possible to keep in

close touch with the officers and committee members in each of the component county societies, of which there are twenty-one. The rural people of New Jersey are familiar with urban life and procedure, and this no doubt makes it possible to promote new procedures more rapidly than in some other states. One big factor to be noted in the New Jersey Medical Society's work is that a large number of members of a society are members of its committees and all are *active* in their assigned fields. One gets out of anything exactly in proportion to what he himself puts into it in the form of effort and interest. Those who are most interested and active in the medical society are those who always work hard in the interest of the profession when called upon. True it is, as Elbert Hubbard has so pertinently remarked, that "The reward for work well done, is *more work.*"

The Medical Society recognizes many defects yet to be overcome, and is endeavoring to correct these as they arise, and as suitable ways and means can be devised. Experience is the best teacher, especially of professional groups.

GENERAL PROCEDURE

The successive steps by which the State Society reaches through the Component Society to its individual members follows pretty much the same plan in each project.

1. When a state-wide project or activity is inaugurated, it is placed in charge of a committee of The State Medical Society, a special committee being appointed if necessary.

2. The State Committee secures the appointment of a similar committee in every County Society.

3. The Executive and Officers of the State Society keep in close touch with every committee; and the facilities of the Executive Offices in Trenton are used in coördinating effort through personal visitation, correspondence, and mimeographed circulars of information.

4. "The Journal" of the Society is constantly used as a medium for conveying information to the members and to record the progress made in the local societies.

This plan has a three-fold benefit:

It promotes action by the local societies and members.

Every County Society must give an account of itself and its activities.

The active societies are assisted and encouraged to set the pace in accomplishments. The slower societies are spurred to action by the demonstrations of the leading ones. Competition is keen but friendly.

The backward societies are not permitted to remain in a state of indifference. They are at least informed of the standards, ideals, and accomplishments of the others. Once the spirit of adventure is caught and competition stimulated, the members become enthusiastic workers in their Medical Society. To sustain their enthusiasm is the real problem in furnishing organized medical services in a community project.

MEDICAL PRACTICE MUST REMAIN UNHAMPERED

Private medical practice permits great flexibility in plan and procedure. This type of medical service gets the best results in the individual case. Better organization for the distribution of medical service need not change the type of service which has been proved best by experience.

Those who sponsor the regimentation of medical service with its ever-increasing standardization of thought, procedures, and fees must also expect an increasing rigidity of *procedure,* and a predominance of the "average" in performance and accomplishment, to accompany the "average" in fees.

Leaders in any profession must attract to themselves adequate rewards, including sufficient financial return to enable them to devote their individual attention to their work.

The philosophy underlying the procedures in The New Jersey Medical Society's projects in furnishing selected medical services in the community involves a consideration of:

1. The varied mental and physcial response of individuals to the same stimuli.

2. The relative contributions of experience and theory in determining the procedures recommended in furnishing medical services.

3. The extent of, and obligations for, free

contributions of service by physicians under past and present conditions and governmental philosophy.

4. Attempted dictation of medical procedure and reward by laymen.

5. Paradoxical voluntary payment for luxuries in amounts which exceed the cost of necessary medical services which is claimed by many to be prohibitive.

6. Decline in self-reliance and individual responsibility encouraged by governmental and lay "social" agencies.

7. Failure of educators and social workers to focus on *essentials* in "Health Education".

8. Experienced medical leaders needed to plan and provide essential health services in the community and pertinent subject matter for education of the public.

9. Determination of the aims and the scope of contributions of community agencies as to their health implications.

The Medical Society believes that experience and training in medical practice impresses upon its members the marked variations, both mental and physical, of individuals to the same stimuli, and will best fit them to provide essential services to meet health needs. We believe that there is a decline in self-reliance and initiative of the people as a result of pampering by private and governmental social agencies. Honest debt should be paid by the individual who contracts them, except in proven cases of indigency the cause of which is unavoidable or uncorrectable at this time. For those whose plea of indigency is convincing, free services should be provided by the community. Free services are offered by private physicians to those for whom no provision is yet made by the community. No one should be provided with essential services without cost, who can purchase "luxuries"; and any tendency to shirk responsibilities in the hope that others will provide these essentials is un-American and unworthy of support. No individual who, through no fault of his own, is urgently in need of free medical services, should be deprived of these essentials because of poverty.

ALLERGY IN CLINICAL MEDICINE

By ROBERT A. COOKE, M.D., New York, N. Y.

From the Department of Allergy, Roosevelt Hospital, and the Department of Medicine of the New York Hospital and Cornell University Medical College. Read before the 168th Annual Meeting of The Medical Society of New Jersey, in Atlantic City, N. J., June 6, 1934.

The object of this address is to add to the appreciation of the manifold evidences of the *allergic reaction* in man, with emphasis on the *clinical approach* to the solution of the problem—in other words to present something that will be of practical value to the general practitioner. We shall discuss some of the various clinical reactions that are allergic, and give cases illustrating various types of the condition.

APPEAL TO THE GENERAL PRACTITIONER

The manifestations which we call allergy, and which include those so-called "idiosyncrasies" of former days, are not new to clinical medicine; allergy is but a new name for the condition, the study of which has taken a new direction and a new scope during the last twenty years because of a greater understanding of the mechanism underlying some of the reactions. It is not yet entirely granted that it is a field of great importance to the general practitioner. This, I believe, to be erroneous and the result of a lack of appreciation by the profession of its many forms and clinical expressions, due partly to the fact that clinical allergy has received little attention in medical schools, and more largely because so many of the reactions we call allergic are not yet adequately explained and proven. Many gaps in our knowledge still exist.

While in the development of certain fields of medical science (such as allergy) intensive

application—in other words specialization—may be wise and necessary to an orderly advance, it is also true that a time arrives when the established facts should become a part of the armamentarium of the general practitioner in diagnosis and treatment. It is my belief that such a time has arrived for allergy, which should be considered as but a part of internal medicine. The specialist in allergy can never be fully successful without a thorough knowledge of internal medicine. So also the internist and general practitioner must know something of the fundamentals of allergy if he would grasp the significance of many of the clinical disturbances he is called upon to diagnose and treat.

TIME FOR REACTION

First, let me call attention to a point of fundamental importance. I will speak frequently of immediate and of delayed clinical reactions. In the immediate type, the reaction—be it asthma, coryza or any of the other manifestations—begins promptly; i. e., within one hour of contact with the exciting substance, and the skin test is usually positive in a few minutes. With delayed allergies the clinical reaction occurs in from two hours to two or three days after contact with the specific allergen and the skin test is negative.*

The positive skin test as in pollen cases, being itself an immediate reaction, can indicate the cause only in the immediate clinical reaction. A delayed skin test with foods and pollens occasionally occurs but unfortunately has no definite significance. I do not refer here to delayed tests such as the Schick and tuberculin tests, which of course are important, but these forms of bacterial allergy are very different.

ASTHMA

It is now generally conceded that true asthma is an allergy. Of course one must exclude such causes of dyspnea as pleural, cardiac, renal and pulmonary diseases, mechanical interference with respiration and certain chemical alterations of the blood. The positive findings substantiating a clinical diagnosis of asthma are a well-marked eosinophilia in the bronchial or nasal secretions and typical sibilant sounds in the chest. The skin tests may or may not be positive, depending on the kind of allergy involved. Asthma[1] in *infants* is practically always due to acute respiratory infections or to a sensitization to food. In *children* and *young adults* it is usually due to a sensitization to airborne substances. Infections and foods play a less important rôle. Asthma in *older adults,* beginning after the age of forty years, is usually the result of infection which is primary in the upper respiratory tract. The infective asthma of infants is usually associated with fever; the food allergies are associated with urticaria, vomiting and obvious abdominal pain. Children and young adults having asthma from airborne substances will be relieved in twenty-four to forty-eight hours if removed to a dust-free room where bedding and pillows are clean. House dust is the commonest cause of asthma of this type. What the irritating factor in dust may be and whence it comes we do not know. In adults over forty the presence of sinus disease is presumptive evidence of infective asthma, and in most cases is the cause; hence the point of attack is the sinus rather than the chest.

With careful clinical history and physical examination then, bearing these points in mind, one can usually, though not always, make an approximate diagnosis of cause without resort to skin testing. The skin reaction has its value but also its very definite limitations due to technical difficulties and to errors in the reading and the interpretation of the tests. Only in those asthmas due to foods and airborne substances, which belong in the group of immediate reactions, may the specific cause be determined by skin test.

Asthma due to infection is a delayed reaction. There is no satisfactory skin test for these cases. Even a delayed vaccine reaction does not indicate an asthmatic sensitization, although it probably does indicate a bacterial allergy.

ALLERGIC CORYZA

The seasonal type, so-called *hay fever,* is usually due to pollens. Here skin testing for

* For further discussion by the writer see chapter on Disease of Allergy: Internal Medicine. Its Theory and Practice, edited by John H. Musser. Lea and Febiger, Philadelphia, 1932.

diagnosis and treatment by injection has proved justified by results achieved. Only within the last two years have we shown that the active pollen antigen is a protein, and these findings have been confirmed by other investigators. These cases form a very important group for research in the underlying mechanism of the immediate type of allergic reaction the fundamentals of which, its cause and the nature of therapeutic protection, are still not known.

Entirely analogous are those cases of perennial *hay fever* due to airborne substances. For the diagnosis of these the environmental test, a change to dust-free environment, as used for asthma, offers a clinical approach to the solution of the case. Emphasis, I believe, might well be placed on the importance of these cases on account of the frequency with which they are associated with recurring nasal infections which in time may become chronic, and since these individuals are allergic it may eventually assume the form of a hyperplastic sinusitis and later on infective asthma. When by a skin test there is a proven causative sensitization, these perennial cases are often remarkably benefitted by injection of the proper antigen, and recurring infections are frequently prevented, thus lessening the chances of their becoming chronic.

HYPERPLASTIC SINUSITIS

There is an increasing acceptance by rhinologists of the allergic basis for the organic lesions of the nasal membranes known as *hyperplastic rhinitis* and sinusitis including polyposis. In a recent publication[2] by Grove and the writer, this subject has been fully discussed, but in brief our reasons for the belief that this condition is allergic are based upon the following findings:

1. Frequent positive history of antecedent allergy.
2. The presence of other clinical allergies in 30 per cent of the cases.
3. The frequency of other sensitizations with positive skin test.
4. The almost constant finding of eosinophile cells in the sinus discharge and membrane and in the sputum. Blood eosinophilia is less common.
5. The reaction of sinus membrane to subcutaneous injection of autogenous vaccine, which we have observed in cases with permanent antral windows.

But there are a number of allergists and rhinologists[3, 4, 5, 6, 7] who believe that hyperplastic changes are produced by allergic reactions to foods and airborne substances to which the patient may be sensitive. It is true that many of these patients are allergic to foods or inhalants and can be proven so by skin test but the allergic reaction on contact with these allergens is purely a vasomotor one. Let me cite an illustrative case:

> A physician sixty years of age had nasal symptoms for twenty years. Examination and x-rays disclosed an extensive polypoid and hyperplastic condition of ethmoids and antra. He was found by test to be extremely sensitive to milk. Abstinence from milk greatly relieved symptoms by relieving the vasomotor edema but after some months the hyperplastic tissue had to be removed.

This type of food reaction in adults is unusual. A reaction to inhalants is common. Our position with regard to these cases is that the hyperplastic change is due solely to a *localized* infection to which the individual is allergic. He develops this type of reaction because of the underlying inherited allergic constitution. Allergy to foods and dusts may co-exist and usually antedates the bacterial allergy, but such reactions produce vasomotor, not organic, changes which accentuate the symptoms, and hence must also be controlled. One of the important reasons for poor results from nasal surgery on these cases is the lack of appreciation of the frequent and important part that these vasomotor allergies play. As it is true that one cannot cure a hyperplastic rhinitis or polyposis by specific injections to which a patient is sensitive, so also is it a fact that vasomotor allergies will not be controlled by surgical procedures even though they were properly indicated by polypoid and hyperplastic changes. I venture to say that no group of our cases gets more lasting benefit from nasal surgery than these—long regarded as the bane of the rhinologist—provided of course that the surgery be good and that all existing vasomotor allergies be properly diagnosed and treated. Let me cite a case illustrating these points:

A patient, male, aged fifty, had a history of asthma from the age of eight. There was a well-marked family history. He was sensitive clinically and by test to many animal danders, dust, and feathers. From about the age of sixteen he was subject to recurring respiratory infections of sinuses and chest, some of which produced asthma of a severe type. With increasing years the nasal infection became chronic, with the development of hyperplastic pansinusitis and chronic asthma. Injections of dust and vaccine did not control the sinus infection, which had progressed too far and had become the important and controlling factor for asthma.

Radical antrum and ethmoid operations were done. The asthma disappeared and for six months following operation the nasal condition was satisfactory. Then nasal symptoms recurred. There was sneezing, nasal obstruction, and excessive mucoid discharge—all vasomotor symptoms—and frequent mild infections, but without asthma. At this time injections of dust extract and horse dander with which there was contact soon checked the vasomotor reaction.

Now, two years after operation, asthma is absent, there is no nasal discharge, no nasal symptoms, even the tendency to respiratory infections appears to be controlled.

ECZEMA AND DERMATITIS

I hesitate to mention these conditions because from the allergist's standpoint little of fundamental importance has been discovered. They are discussed together because I believe that there is no justifiable clinical differentiation, and our present knowledge does not warrant a distinction which is therefore artificial.

Some headway has been made on the etiological diagnosis of dermatitis of external contact. Some years ago when we were studying rhus poisoning[8] I devised the patch test to duplicate external contacts because intradermal injection of ivy extract did not produce the local lesion. This test is applicable for all external contacts such as the metals—nickel, arsenic, mercury, gold—aniline dyes, oils and resins of primula, ivy, geranium, and other plants and woods, and such compounded substances as hair lotions, face creams, toilet powders, cleaning fluids, soaps, and a host of others. The patch test works, and works well, if there is a general sensitiveness, but often there is not. If the clinical lesion is localized, skin sensitiveness may be localized as well, as is shown in the following patient:

A case from our clinic with dermatitis of the eyelids ackhowledged the occasional use of a certain eyelash dye. A patch test with the patient's preparation applied to the soft skin of the inner arm was negative after three days. After several weeks the lesion disappeared from the lids. A few days later reapplication of the dye reproduced the lesion on the third day. This is a typical example of a strictly localized allergy to aniline dye.

Another example of localized allergy from ingested food is shown in the case of a woman aged thirty-eight, who gave a history of dermatitis involving the lids of the right eye. It occurred only in the summers of the past three years. A diet was arranged excluding summer fruits and vegetables. After the lesion was cleared for a time certain fruits and vegetables were added. We decided finally after trial and error that tomato was the cause. Eating raw tomato produced the lesion in twenty-four hours; cooked tomato required larger amounts and a longer time. Intradermal and patch tests on the skin of the arm with tomato juice were negative. External application of fresh tomato juice to the lids of both eyes each night produced the eruption on the fourth day on the right eye only, quite a severe attack.

The lesions that are still baffling us are those that possibly result from ingested substances, foods or drugs, for it is in this class that the infantile eczemas seem to belong. Intradermal or scratch testing has been unsuccessful in our hands, although results are claimed by Hill.[9] It is true that many infants and children with eczema give positive intradermal tests; but it is not true, at least in my opinion, that such tests indicate a cause of eczema. Clinical results from treatment based on such tests have not borne out the hypothesis. As a matter of fact, many of these children with eczema have been or are asthmatic, and the positive tests are an indication of the cause of asthma rather than the eczema. There is no apparent explanation for the current belief that the immediate urticarial wheal of a skin test indicates a factor or allergen which, if ingested, will produce the clinically delayed exudative skin lesion which we call eczema. I will report a case which illustrates the point.

An infant with severe generalized eczema was gradually improved under routine hospital care until the skin became practically normal. Intradermal tests then showed that cornmeal among other things gave a positive immediate wheal. Passive transfer tests with the infant's serum were also positive. Feeding cornmeal as cereal produced an urticarial attack, but not eczema. The cause of the eczema which gradually returned on her return home was not discovered. The point is that the positive skin test was not an indication of the cause of eczema. Ingested cornmeal could repro-

duce only the histological and immunological type of the test reaction.

Infections are of course important causes of dermatitis. General skin reactions arising from localized lesions of trichophytin and endophyton infections are now recognized, and presumptive evidence of the allergic nature of such infections is afforded by the positive delayed reaction of the tuberculin type to intracutaneous injections of culture filtrates now commercially available. Less well recognized are the skin reactions to such organisms as the staphylococcus and streptococcus. These cases too may give skin reactions to tests with culture filtrates. We have records of a few such cases where the primary focus was sinus or tonsil.

ALLERGIC STOMATITIS

Not infrequently one elicits from allergic patients the statement that they are subject to attacks of soreness of the mouth or throat; and often this symptom is associated with one or several typical canker sores of the tongue or buccal membranes. In fact, these patients are often able to tell the exact cause. We have one patient, an asthmatic, who had great trouble from stomatitis which was traced to nickel alloy in a dental plate. To nickel she was also skin sensitive by patch test. Nuts, especially walnuts, are frequently mentioned, but other foods, such as strawberry, tomato, rhubarb and coffee have been implicated. Drugs of the barbital group are also known to produce ulcers of greater or less extent. Observant patients are also able to state quite explicitly the time of appearance of the lesion, usually from ten to twenty-four hours after ingestion. Thus far very little attention has been paid to this minor ailment. During the past year I have seen a case with the most extensive lesion of the mouth and tongue, which I will present in greater detail.

A girl, aged fifteen, was first seen in April, 1931, suffering from urticaria and dermographia beginning at the age of seven. The paternal uncle has hay fever, and the paternal grandmother had asthma. Her diet has been a normal one. There was no difficulty with feeding in infancy. She had had the usual diseases of childhood. Adenoids, but not tonsils, had been removed in infancy. For several years urticarial wheals were general and spontaneous and very slight scratching of the skin produced immediate welts (dermographia).

The physical examination was negative save for tonsillar hypertrophy and slight enlargement of the thyroid. Intradermal food tests were all negative. Leucocyte and differential counts were normal. There was no eosinophilia. Various restrictions of the diet produced no results. In October, 1932, she had an attack of abdominal pain and an appendectomy was done. Later that fall a Schick test for diphtheria produced an enormous reaction with local necrosis. In April, 1933, a tonsillectomy was done, and later a septal operation.

For the past two years she has been subject to abdominal pain of moderate severity, not colicky but constant for days at a time. Hives and dermographia have continued, and they and the pain are less on a diet which she has restricted to the point of losing weight. In October, 1933, she had an attack of so-called herpes of the mouth and lips associated with abdominal pain. Two weeks later she had a second attack, and about three weeks later the third, at which time gastrointestinal x-rays, test meal, chest x-rays, and blood examination were all negative.

On January 10th she entered the hospital for observation in good physical condition complaining of continuous mild epigastric distress rather than pain and occasional hives. After two days of a diet containing two quarts of well-boiled milk, butter, and melba toast she woke with swollen lips. The next day lips were still swollen, and discrete vesiculo-papular lesions had formed on both sides of both lips at the muco-cutaneous junction, and there were a few similar lesions on and under the tongue and on the roof of the mouth. On the following day (the 15th) the lips were very swollen, and the mucous membrane was a mass of large flat vesicles or bullae, and the entire mucous membrane of the mouht and tongue was one irregularly confluent mass of superficial ulceration with a yellowish slough at the base and hyperemic edges. The tongue was swollen to twice its normal thickness. There were a dozen discrete vesiculopapular lesions over the center third of the face from forehead to chin. The glands of the neck were swollen and tender. There was salivation and swallowing was impossible. There was no temperature. The leucocyte and differential counts were normal. The lesions remained at their height for two days, during which time there was a marked increase in abdominal pain. The lesions then rapidly healed and at the end of seven days from the onset her condition was as it was on admission. Smears from the mouth lesions did not show Vincent's organisms. Cultures from the mouth showed staphylococcus and streptococcus, both hemolytic and nonhemolytic, and colonies of yeasts only. Cultures of the stools showed oidium but no monilia, and several strains of colon bacillus.

Five weeks after this attack, while at school, she had the fifth one lasting but three days. With this attack there was excessive fatigue and listlessness, but in other respects it was identical but much milder than the attack described.

While time and further observation are necessary to establish this case as an allergic reaction, the

presumption is in favor of such an hypothesis. The severity of the attack is such that one is not justified in experimental clinical reproduction of the attack. It is our present opinion that it is an unusual form of allergy to milk and probably to egg. There may be other allergens. Such a theory is not incompatible with the facts. Clinically, the attack has none of the earmarks of a lesion that is basically infective. Here again we have a reaction that is of the delayed type with negative skin tests, and the diagnosis can be made only by clinical observation.

ALLERGIC PURPURA

In 1914 Osler,[10] writing on the "Erythema Group", raised the question as to whether or not anaphylaxis might not be the explanation. In 1927 Alexander and Eyermann[11] reported three cases in which allergy and Henoch's purpura were associated. Again in 1929 these authors[12] reported six cases in which this type of purpura was identified with allergy and in each case demonstrated that the ecchymoses, abdominal pain and urticaria were caused by particular foodstuffs. In two other cases the association was observed but the cause could not be determined. Nine other cases of allergy gave a history of purpura. Barthelm[13] in 1930 reported another clinically proven case. During the past year I have observed another case in which milk, among other foods not yet fully determined, will cause ecchymosis, abdominal pain, tarry stools and hematuria. The skin tests with milk were negative. After ingestion of 200 cc. of milk an attack developed on the second day. Several years ago we had at our clinic a patient, female, age forty-five, with severe asthma. She was sensitive to dust and feathers, and had a pansinusitis. She gave a history of having had a number of short attacks of hematuria associated with lower abdominal pain. There were no skin ecchymoses. She was seen by Dr. Alfred Osgood at the close of one of these attacks, who found on cystoscopic examination numerous petechial or purpuric spots in the mucus membrane of the bladder and suggested it might be due to iodide medication. This idea was confirmed by subsequent clinical test. About ten hours after the ingestion of five grains of sodium iodide, bloody urine was passed for a day. There were no skin lesions and no symptoms of lesions in other viscera.

It may properly be recalled that these allergic purpuras, the so-called Henoch's (with abdominal pain) and Schonlein's (with arthritis), are classified as ideopathic or non-thrombocytopenic; that is, they have no recognizable blood changes as regards clotting and bleeding time, number of platelets, and retractility of the clot. We have at the present time no explanation of the mechanism by which the bleeding is produced, but in the absence of blood changes the tissues at the reaction site must be responsible, producing either capillary rupture or perhaps local hemolysis.

Practically all of these cases cited belong to the delayed reaction group with negative skin tests except one cited by Alexander and Eyermann[12] and Barthelm's case.[13] This latter in my experience is extremely irregular in that tests were said to be positive and the clinical reaction time was from twelve to twenty-four hours. In short, one cannot expect to diagnose the cause of this type of delayed allergy by means of the skin test. We use restricted diets with the addition of suspected foods and watch for clinical results.

THE URTICARIA AND ANGIO EDEMA GROUP

These groups are particularly interesting and important. The conditions are discussed together since the association of the two lesions is extremely common, but not necessary; and as mentioned above, they may be associated with purpura, simple erythema, and dermographia. The lesions may be external alone, internal alone, or both. The internal lesions may affect various tissues or organs; hence we may have abdominal or cerebral manifestations.

Considering the group as a whole, the causes are manifold and include ingested foods or drugs and foci of infection usually suppurative. This latter form of bacterial allergy is not as well appreciated as it should be. The following is a good illustration:

A patient, male, age forty-seven, was referred by Dr. Leander Shearer in January, 1933. For two months he had had occasional urticarial lesions which had become severe a month before, and were associated with large superficial swellings and with severe epigastric pain radiating up the chest (esophagus). Ingestion of almost any food seemed to aggravate both pain and urticaria. His mother had

headaches (migraine) all her life. A sister had urticaria.

Physical examination showed a man who had obviously lost weight, was anemic (hemoglobin 60 per cent) and had generalized urticaria. Abdominal examination and gastro-intestinal x-ray examination were negative. Urine was normal. Leucocytes 11,000, with 15 per cent band cells, and but two per cent eosinophile cells. He was found to have a suppurative infection of the right antrum which was drained, and from which hemolytic staphylococcus aureus, streptococcus viridans and colon bacillus (nonhemolytic) were cultured. His blood showed no agglutination of these organisms. At subsequent washings a hemolytic streptococcus appeared. The intradermal test with one per cent suspensions of these bacteria was negative both for immediate wheal and late reaction (tuberculin type), and the skin test with a sterile filtrate from the first antrum washing was negative. All intradermal food tests were negative except to tea, which he never used, but which later for clinical test he did take with impunity. The important point is that the urticaria practically ceased within forty-eight hours of his first antral irrigation and without any other changes in diet, medication or treatment. Hemoglobin rose to 70 per cent in three weeks, and to 80 per cent in five weeks ,when band cells dropped to 2.5 per cent. Necessary dental extractions were done, and later in May, 1933, a radical ethmoid and antrum operation was performed by Dr. R. C. Grove. There was uninterrupted convalescence. When he was examined one month ago, the patient was normal.

GASTRO-INTESTINAL ALLERGY

It is not possible to state the exact nature of the lesion in each case, but it must be analogous to those seen in the nose or to the visible urticarias and angio edemas and in some cases the purpuras.

An allergic reaction, however, may give rise to symptoms that may be classified under the headings of simple indigestion, acute gastro-enteritis, chronic diarrhea, or mucus colitis; and to attacks simulating the acute surgical abdomen. I will not go into detail here since my ideas have not altered from those already published.[14] In these abdominal cases we have both the immediate and the delayed clinical reaction. The immediate type is usually diagnosed by the patient and may be confirmed by the positive skin reaction in almost all cases. It is the delayed reaction with negative skin test to which greatest importance is attached; and the diagnosis rests upon a recognition of the possible allergic nature of symptoms for which there is no adequate explanation after a careful examination for organic disease. A negative examination in a patient known to be allergic gives the clue to the direction along which one may find the solution.

To the surgeon as to the medical man these intestinal forms of allergy are important. Most of the cases of angio edema with acute abdominal crises that have come under my observation have had laparotomies performed. Withington[15] in 1912 reviewed a series of cases of abdominal purpura and angio edema in some of which operation was unnecessary and even harmful. In the group associated with purpura, however, he states, "We are not to assume that surgical interference may not, in certain cases, be urgently and promptly required."

CEREBRAL ALLERGY

Let us now turn to a consideration of certain cases with evidences of cerebral lesion. Migraine has been considered as a possible allergic reaction. A patient, female, age forty-five, complaining of asthma, gave a history of migraine antedating asthma by many years. Asthma was caused by certain substances to which she was skin sensitive by test and also by infection (chronic sinusitis). The test with chocolate was positive. An immediate pseudopod wheal was produced, and so also at the same time was a typical migrainous attack which lasted twenty-four hours. In only two other instances, however, among several hundred tested cases was the positive immediate reaction indicative of the cause, one being sensitive to egg, the other to asparagus. Hence skin tests are not important in migraine.

From time to time in the literature there have appeared reports of various functional cerebral lesions attributed to allergy. Kennedy,[16] Duke,[17] Miller,[18] Vaughan[19] and numerous others have reported cases of epilepsy, Meniere's disease, aphasias, motor, sensory and visual disturbances, in which an allergic reaction involving the brain was in most cases the apparent cause.

About one year ago I saw with Dr. Foster Kennedy a case in which the diagnosis between an encephalitis and cerebral angio edema was extremely difficult. The patient had no antecedent family history of allergy but was himself sensitive to pollens to which he reacted on test and he also had attacks of abdominal pain from many unre-

lated foods to which he did not react. In June, 1932, he became blind in the right eye with normal fundus, but large central scotoma. There was paresthesia of the right side of the body and he passed into a state of somnolence and delirium for five weeks. He then made a rapid and complete recovery and was well for three months when he had a return of blindness in the left eye, of short duration. Twenty-four hours after taking beef, egg, milk, or ham he had a return of paresthesia on the right side. To these substances he is negative by skin test. On strict diet he has recovered. The difficulty lies in providing sufficient nourishment. This is a very condensed résumé of a well-substantiated case of allergy with a central lesion of angio edema of the delayed type with negative skin tests.

While it is true that an occasional case of this urticaria-angio edema group, external, gastro-intestinal, or cerebral, may be diagnosed by the skin test with its positive immediate reaction, in the vast majority of cases the tests are negative, or, if positive, do not have clinical significance. At the present time we must resort to physical examination and clinical observation with known intake of foods and drugs.

BASIC CONSIDERATIONS

We have now in a very brief way surveyed such clinical allergies as asthma, hay fever, hyperplastic sinusitis, dermatitis, stomatitis, purpura, the urticaria and angio edema group including those with abdominal and those with cerebral manifestations. It is obvious then that the field of allergy is very general, and since its basis is biological with different immunological and histological reactions involving different tissues in many parts of the body, the clinical evidences are of importance to the general practitioner, and also to the specialist whether he be internist, surgeon, pediatrician, or one whose interest lies in any of the other specialties, the lines of which are drawn on an anatomical basis.

Let us depart now from the purely clinical field, and see if from what has been said and from cases cited it is possible to get some idea of a few important basic facts.

We know that antecedent allergy is an important predisposing cause. We do not know the reason for the development of a specific allergy to a specific substance in the particular case. Histologically, the allergic lesion may be an edema, an erythema, or it may be hemorrhagic as in purpura, exudative as in dermatitis, or inflammatory as in the tuberculin test. Immunologically too there are great differences. We have spoken several times of the immediate *clinical* reaction as well as the delayed, and of the immediate *test* reaction. Contact with pollen or danders or foods will give an immediate clinical reaction; that is, within one hour, if the individual is properly allergic; and, practically speaking, all such cases will give the immediate skin test to the proper substance. These are the cases in whose serum an antibody can be demonstrated by the method of passive transfer. On the other hand, if the clinical reaction is delayed from about two to forty-eight or even seventy-two hours after contact, the skin test will be regularly negative. Under these conditions a proven allergen does not produce even a delayed skin test. At times one does observe delayed reactions to tests of foods, but there appears to be no significance to such reactions. The mechanism of these reactions is not at all understood; therefore the clinical test, the method of trial and error, has to be resorted to in diagnosis. But one point is important in these tests. The time interval between contact and clinical reaction is practically fixed.

EVIDENCES OF ALLERGY

I will in conclusion merely mention the following points upon which a presumptive diagnosis of allergy may be based:

1. Since heredity is important, a history of allergy in direct and collateral antecedents, brothers, sisters and children, may be significant.

2. A history of other allergies, past or present, is of value. Over 50 per cent of all allergies have multiple sensitization. It may be that a number of unlike allergens—food, danders and pollen—may cause a single clinical allergy such as asthma; or a case of, let us say, asthma, may have urticaria, migraine and gastro-intestinal disturbance from one substance, but usually from different substances.

3. One striking peculiarity of clinical allergy is the frequent repetition of attacks or its distressing chronicity. This is evidenced in practically all of the cases cited. Therefore,

though usually not serious from the standpoint of mortality, the morbidity is high and allergy is a serious problem for the patient unless properly and carefully studied for the cause; hence it deserves the serious consideration of the physician.

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DISCUSSION

Dean W. Marquis, M.D., East Orange: In his paper, Dr. Cooke has emphasized the difference between immediate and delayed allergic reactions. This conception is very important in the study of a case. A careful history and physical examination should reveal much information. The trial and error tests, environmental change, and elimination of infection—methods referred to by Dr. Cooke—are often necessary to find the excitant. Some attach too much significance to skin tests. Others feel they are worthless, because of many disappointments. When it is generally understood that only *immediate* allergic reactions can be detected by skin tests, both viewpoints will be corrected.

Certainly the time has come when no patient should be told his eczema is due to an "acid condition". I frequently find patients who have been deprived of certain food groups, such as sugars, starches, or the citrous fruits. Though multiple sensitivities are not uncommon, these are more apt to be individual substances rather than all members of one food class.

In asthma, Dr. Cooke has pointed out the importance of age in helping elicit the cause. In small children foods and respiratory infection play leading rôles; later inhalants occupy the center of the stage; and after early middle age, infection again assumes the greatest importance. This knowledge of probabilities aids us considerably.

I do not believe referring allergic patients to druggists or commerical extract houses for diagnosis is a solution to the problem of allergy. Hypersensitiveness is part of medicine and it is our responsibility as doctors to keep abreast of its advances.

A presentation such as this is very fortunate in that it gives us a much clearer picture of allergy in its many forms. We certainly should thank Dr. Cooke for such a comprehensive discussion.

George P. Meyer, M.D., Camden: The paper which Dr. Cooke has presented is directly concerned with our attitude towards asthma, hay fever, hives, eczema, and also the other less typical forms of hypersensitiveness. It seems especially timely in calling attention to the shortcomings of skin testing as a solution of the problems raised in the handling of these cases.

The enthusiasm for skin-testing has arisen in connection with the brilliant and comparatively rare cases in which it, without other aid, provides the solution to the problem of how the particular individual who is hypersensitive must be treated. Dr. Cooke believes that in the case of the common non-seasonal forms of coryza called *vasomotor rhinitis* and in the case of the commoner dermatologic forms of hypersensitiveness, such as certain forms of eczema, and urticaria, much more than skin testing of the ordinary kind is necessary. He has particularly emphasized the importance of infection as the cause of the hyperplastic sinusitis which so frequently accompanies the so-called vasomotor rhinitis and has given us reasons for this attitude.

It may seem that these conditions become more complicated when viewed thus. But an impartial and critical examination of the results achieved by skin tests alone in these conditions will strongly confirm their inadequacy. The very great importance of the history in helping to judge their probable value is, as he has pointed out, a help.

At a time when the field of allergy is rapidly expanding, and a larger attention is being given to it by those who have not had a prolonged and intimate contact with the art of testing the skin for hypersensitiveness, it is good to hear of its limitations from one of the earliest workers and principal originators in the field; one who is able to judge its excellence. If we extend the scope of our investigations into the field of chronic infection, usually of a focal nature, seems to stand foremost, we will be on the way to a more satisfactory treatment and a more intelligent handling of such cases.

PNEUMONIA IN ADULTS

By Lewellys F. Barker, M.D., Baltimore, Md.

Read before the General Session of the Medical Society of New Jersey in a Symposium on Pneumonia at the Annual Meeting in Atlantic City, N. J., June 7, 1934

This symposium has been planned with a view to the needs of the general practitioner rather than the specialist. I shall, therefore, restrict my comments largely to a discussion of the commoner forms of pneumonia, for it would seem desirable to deal with the causes, the recognition, and the management of these rather than to go into detail concerning the rarer forms, or to spend time upon matters that are of more theoretical than practical interest.

EXTENT OF LUNG INVOLVEMENT IN PNEUMONIAS

The acute inflammations of the lung that are due to infections and that we call "pneumonias" are not all of the same form; as everyone knows, clinicians make a distinction between lobar pneumonia and lobular or bronchopneumonia, partly because of the extent of the lung substance that is involved, partly because of the presence or absence of bronchitis preceding the pneumonia, and partly because of differences in the general clinical picture.

Since in genuine croupous pneumonia, it is usual to find a whole lobe or even two or more lobes involved, this disease is often called "lobar" pneumonia; moreover, it is of sudden onset, usually without clinical evidence of preceding bronchitis. In bronchopneumonia, on the other hand, the onset is more insidious; a bronchitis usually occurs first and is followed by multiple small focal infiltrations of both lungs—hence the term "lobular" or "focal" pneumonia.

THE CLINICAL SYNDROMES DUE TO PNEUMONIAS

The ordinary *clinical picture of lobar pneumonia* is familiar to every general practitioner. It is characterized by sudden onset with chill, rapid rise of temperature, pain in one side of the thorax, and acceleration of the rate of respiration and of the pulse. On the second day, herpes of the lip is often seen, the cough becomes violent and painful and sputum, containing red and white blood corpuscles, small fibrin casts of the bronchioles, and encapsulated pneumococci, is expectorated. Abnormal physical signs in the chest usually become evident by the second or third day—crepitant râles and increasing dulness to be followed later by outspoken dulness, loud bronchial breathing, increased vocal fremitus and bronchophony. The white cell count in the blood rises to 15,000 or even to 40,000, and the sodium chloride output in the urine becomes greatly diminished. These signs and the high fever continue for several days (4 to 11) until the crisis occurs, when the temperature falls abruptly, the patient perspires profusely and convalescence sets in, after which signs of "resolution" of the exudate begin to appear. In some cases the temperature falls suddenly without outbreak of perspiration; after such a pseudo-crisis the temperature rises again. Occasionally, the temperature in lobar pneumonia falls by lysis instead of by crisis. A rise of temperature after a critical fall makes one suspicious either of development of pneumonia in another lobe or of a purulent pleural exudate (empyema). When death occurs in lobar pneumonia it is more often due to circulatory failure than to any other cause, so that the physician observes closely the quality and frequency of the pulse and the behavior of the blood pressure.

Certain *atypical forms of lobar pneumonia* may be met with, among which I would mention especially *central pneumonia* discoverable in x-ray plates, *massive pneumonia* with intense dulness but without râles or bronchial breathing because of plugging of the bronchi by fibrin, *ambulant pneumonia* in which the patient despite the pulmonary inflammation remains up and about, and *senile pneumonia,* which is often complicated by abscess or gangrene of the lung and has a high mortality rate.

The *clinical picture of bronchopneumonia* (focal pneumonia) is much less definite at onset. Often following upon a bronchitis, there is gradual rise of temperature, frequently without chill, the temperature is of more remittent type, and the fall of the temperature on recovery is usually by lysis rather than by crisis. The focal distribution of the lesions in the lungs is more easily demonstrable in x-ray plates than by percussion and auscultation. When bronchopneumonia follows an influenzal infection, the face is characteristically red and cyanotic, the pulse is small in volume and the extremities are cool; the dangers of collapse in such patients are great.

THE CAUSATIVE AGENTS IN THE INFECTIOUS PNEUMONIAS

Infectious pneumonias occur in persons in whom natural defences to infection have been broken down, sometimes by earlier debilitating diseases, sometimes by exposure to cold and wet, sometimes by chronic alcholism, sometimes by local infections.

The infectious agent in ordinary lobar pneumonia is the Gram-positive, encapsulated lanceolate diplococcus known as the *pneumococcus*. Though pneumonia of lobar distribution may occasionally be caused by staphylococci, streptococci, Friedlander's bacilli, or tubercle bacilli, the vast majority of lobar pneumonias are due to pneumococcal infection.

Different specific types of pneumococci have been isolated each of which gives rise in experimental animals to specific immunity-substances. For a time, four types of pneumococci were distinguished: type I that causes somewhat more than one-third of all cases of human lobar pneumonia, type II that causes somewhat less than one-third of the cases, type III that causes less than one-eighth of the cases but has a high mortality rate and type IV that causes approximately one-fifth of the cases. So called type IV has been shown to be not a single type; but it is a group of a large number of different specific types of which at least 30 have already been separated by Cooper and others from one another, though only a few of them (VIII, V and VII) occur at all frequently (Sutliff and Finland); these are all of relatively low virulence in contrast with the high virulence of types I, II and III.

Anti-sera to all these types have been prepared by injections into animals and these sera have been used for the determination of the types in pneumonic sputa. Until recently the method for discovering the type responsible or a given pneumonic infection consisted in the injection of some of the fresh sputum into the peritoneal cavity of a mouse, killing the animal after a period of from 8 to 24 hours, washing out the peritoneal exudate, and testing the pneumococci in it for agglutination by anti-sera I, II and III. Last year, an extremely rapid mode of typing was devised. A particle of the sputum to be tested is rubbed on a glass slide with salt solution; a loopful of this mixture is placed upon each of three other slides upon which respectively a loopful of anti-serum I, II or III has been placed, as well as a little methylene-blue solution, and after five minutes the preparations are ready for examination under a high-power lens. If the pneumococcus in the sputum is of type I, II, or III, the cocci in the slide upon which the corresponding anti-serum has been placed will be found to be stained intensely blue but will be surrounded by greatly swollen unstained capsules; whereas, in the other slides, the capsules of the pneumococci will not be so swollen. By means of this "swelling reaction", it is now possible in laboratories equipped for the purpose, to decide in the vast majority of cases of lobar pneumonia due to pneumococci which type is causative, within half an hour after the laboratory technician has obtained the sputum.

Bronchopneumonias, in turn, may be caused by a variety of infectious agents. They may be due to pneumococci (especially types X, III, VIII, or XVIII), but they are much more often due to streptococci or to influenzal bacilli. Bronchopneumonias may follow any form of bronchitis and are then usually due to the same bacterial cause; and they are frequently met with as complications of a whole series of epidemic infections (e. g. influenza, measles, whooping cough, and diptheria). Not infrequently, focal pneumonias occur through

infection of the lung not from the bronchi but from the blood-stream (septic metastatic infections).

THE TREATMENT OF THE PNEUMONIAS OF ADULTS

Since deaths in pneumonia are most often the result of circulatory failure, attention should be paid, from the beginning of the infection on, to the condition of the heart and the blood-vessels.

That the pneumonia patient should be kept quiet in bed goes without saying; indeed as a rule he feels so ill that he goes to bed of his own accord and stays there, though now and then a case of so-called "ambulant" pneumonia is encountered requiring the authoritative order of bed-rest from the physician. Skillful nursing, an adequate liquid diet (milk, fruit juices, soups), a fluid intake of from 2 to 3 litres in the 24 hours, an abundance of fresh air, and protection from over-solicitous friends and relatives are all desirable.

A few decades ago it was customary to resort to blood-letting in the early treatment of almost every patient who had pneumonia (either lobar or lobular). Now-a-days, however, we bleed only in the cases in which we fear the onset of a pulmonary edema or the occurrence of acute circulatory failure; the withdrawal of from 300 to 500 ccm. of blood from a vein at the bend of the elbow may in such cases be of very great benefit.

In the pneumonia of adults it is wise to begin with tonic doses of digitalis as soon as the diagnosis is made. Thus one may give ten or fifteen drops of the tincture or, if preferred, 1½ grains of the powdered leaf in pill form thrice daily. The pushing of the drug to full digitilization may, however, be decidedly dangerous in pneumonia and should be avoided. In case of sudden fibrillation one may inject 1 ccm. of digifolin or better still one-tenth of a milligram of strophanthin intravenously two or three times a day, increasing the dosage very cautiously during the two following days until a total of say 2½ or 3 milligrams has been given. If there be a sudden onset of pulmonary edema at any time, elastic ligatures may be applied at the roots of the lower extremities for a period.

In addition to cautious digitalis therapy every pneumonia patient should be given camphor; from 5 to 10 ccm. of a 20 per cent solution of camphor in oil may be injected intramuscularly twice or thrice daily. If circulatory failure threaten, one may use, in addition, subcutaneous injections every two hours of liquid cardiazol (1 ccm.), coramin (1-2 ccm.), or other similar preparations. The intravenous injection of 200 ccm. of 15 per cent glucose solution occasionally may be a useful adjuvant.

If the circulatory failure be due to dilatation of the peripheral arterioles rather than to myocardial insufficiency, frequent injections of ephetonin or ephedrin hydrochloride (¼ grain) may be administered; or in the event of severe collapse (with tachycardia, fall of blood pressure, and sweating), one may inject 0.5 to 1.0 ccm. of 1-1000 solution of epinephrine every half hour until the danger is passed.

Patients who are markedly dyspnoeic and who become cyanotic because of anoxemia are benefited by the administration of oxygen. In hospitals the modern roomy oxygen tent (with provision for cooling and ventilating) has been found to be very satisfactory, whereas, in private practice, the simple nasal catheter (held in place by adhesive), combined with a high pressure oxygen supply and a reducing valve which will supply from 2 to 5 litres of the gas per minute, will raise the oxygen content of the alveolar air to approximately 35 per cent, and will do very well as a substitute for an oxygen tent or chamber.

When there is pleuritic pain at onset, the mobility of the chest should be controlled by a binder and the pain stilled by small often repeated doses of codein or if necessary by 1/8 to 1/6 grains of morphine, remedies that are also helpful for the relief of the troublesome cough. Many still make use, at the onset, of a thick poultice containing one part of mustard to seven parts of flaxseed applied for two hours and followed by a second poultice free from mustard for another two hours. Recently, artificial pneumothorax on the

affected side has been tried; I have had no experience as yet with the method.

If the sputum be thick and tenacious, the well-known expectorant containing wine of ipecac, wine of antimony, ammonium chlorid, and potassium iodid may be given in teaspoonful doses every two hours.

To prevent gaseous distention of the abdomen, a soap-suds enema once every 24 hours may suffice. If distention should become marked, a rubber tube may be kept in the rectum, and 0.5 ccm. of pituitrin may be injected subcutaneously at intervals.

For restlessness and insomnia, bromides or phenobarbital may suffice. In outspoken delirium, especially in patients who have been alcoholic, one may try paraldehyde (in orange juice) by mouth in dessertspoonful doses, repeated every hour for 2 or 3 doses. Recently, for the delirium of pneumonia, the rectal administration of ethobrome (avertin) has been highly lauded (Bullowa); an initial dose of 60 mgm. per kilo of body weight is introduced into the rectum (after an enema).

Chemotherapy with salts of quinine, with optochin hydrochlorid and with optochin base excited much interest for a time but the results have been decidedly disappointing and the tendency at present is to avoid their use.

SEROTHERAPY

Serotherapy in the pneumonias due to pneumococci has grown steadily in importance since the early fundamental work of Rufus Cole. We know now the kind of cases in which antisera may be expected to be of help; and it is gratifying that sera of much greater concentration in antibodies and less toxicity have become available through the work especially of Felton. Though the field of useful serotherapy in pneumonia is definitely limited, within that field (which in any large series of cases of labor pneumonia corresponds to about one patient in every four) the administration of appropriate sera lessens mortality markedly. The immune serum used must be specific for the type of pneumococcus with which the patient is infected; otherwise no benefit is to be expected. Moreover, it is only for pneumococci of type I, type II and type VII that anti-sera of striking clinical value have been obtained. The serum for type III has thus far proved to be disappointing when used clinically. Furthermore, favorable results may be expected only in the cases in which the immune serum is injected within 96 hours after the initial chill or stitch in the side. Anti-streptococci sera have been used in some bronchopneumonias, but with little success.

In hospitals, with the aid of the new rapid method of typing pneumococci from sputum by means of the "swelling-reaction" of Neufeld (as applied by Armstrong and by Logan and Smeall in Great Britain and by Sabin and others in this country), when the infection is found to be due to type I, type II or type VII, the appropriate serum can be administered very promptly. The details of serum administration have very recently been thoroughly discussed by Finland, whose article should be read by all workers in this field. One makes use of immune sera concentrated by the method of Felton (sera of varying strength are available, though recently more uniform concentrations have been provided, type I serum containing 3500 units per ccm.; type II serum containing 2000 units per ccm.). In treating lobar pneumonia in places in which facilities for typing are not available, one may use promptly a bivalent serum (efficacious for type I and type II) knowing that there is approximately a one to two chance that the infection is of a type that, when treated early, will be influenced favorably by serum.

One should be very cautious in using serum in patients who give a personal or a familial history of allergic disease (such as bronchial asthma, hay fever, urticaria or angioneurotic edema), or in patients who have had serotherapy of any kind earlier. In such persons, tests for serum sensitivity (cutaneous, conjunctival) should first be made and if found to be positive, it may be wise to refrain from the use of serotherapy unless the outlook because of a blood-stream infection or other reason is extremely unfavorable any way, in which event the serum should be cautiously applied despite the danger.

Even when there is no history of allergic disease, great care should be observed in the

administration of the anti-serum. After inserting the needle into the vein, a very minute amount is injected; one then waits for one minute before giving more. If no unfavorable signs develop, one gives at intervals one-tenth of a ccm. until 0.5 ccm. has been given, after which one may inject at the rate of 0.5 cc. per minute until the total first dose of 5 ccm. has been given (say by the end of 15 minutes).

Two hours later the second dose of 25 ccm. may be slowly injected. After another two hours, the third dose of 45 ccm. is administered, the patient thus receiving a total of 75 ccm. in the course of the first six hours. One may then wait six hours after which another dose of 45 ccm. may be given; and, if it seem desirable, doses of from 30 to 45 ccm. may be given at intervals of from 6 or 12 hours until the patient shows definite signs of recovery.

Infections due to type II require somewhat larger doses than infections due to type I. Moreover, the longer after the onset of the pneumonia before treatment is begun, the larger the dosage required. Methods of testing to ascertain whether or not dosage has been adequate are being worked out by laboratory men.

The administrator of anti-pneumococcus serum should be prepared to give epinephrin immediately in case any serious serum reaction is threatened. Thus, if the patient become markedly dyspnoeic, asthmatic, or cyanotic, the syringe containing the serum should be separated from the needle in the vein at once and epinephrin solution should be injected through the same needle. Fortunately, serious reactions of this type are rare; the milder serum sickness that may follow a few days after injection gives no concern. Serum reactions have been, moreover, far less common after injection of concentrated anti-sera of the Felton type than they were formerly after the injection of non-concentrated sera.

The reduction of mortality in suitable cases of pneumonia treated within 96 hours with anti-sera has been exceedingly gratifying. Thus, in type I cases the former average mortality in the United States of 30 per cent can be reduced by sero-therapy to 15 per cent and in some series to 10 per cent; in type II cases the former average mortality of 40 per cent can be reduced to 20 per cent and in some series to 15 per cent. Hence in these two types of cases, sero-therapy should continue to be used. Though failures will occur in old alcoholics with delirium tremens, in some senile patients and in some patients with serious complications, successes may be achieved in a large percentage of other cases that are less handicapped.

Observation of the improvement in a pneumonia patient who responds well to immune serum is a gratifying clinical experience. To see the toxic symptoms rapidly grow less, to observe a temperature fall within 24 or 36 hours to 100° or lower, and to find a patient who has been desperately ill sitting up and reading a newspaper within 48 hours after the administration of serum makes glad the heart of the attending physician. The successes thus far achieved most surely spur us on to ever greater efforts for better control of the types of cases that thus far have proved to be refractory to immunotherapy. Immunologists are continuously searching for the causes of this refractoriness; let us hope that they may find them and discover also ways of compelling responsivity to new forms of treatment that they will devise. Possibly, as W. H. Park hopes, some obdurate forms of pneumonia may yet yield to pneumococcus vaccines that investigators are learning better how to prepare and to administer.

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THE ROENTGENOLOGICAL DIAGNOSIS OF LESIONS OF THE OESOPHAGUS

By C. F. BAKER, M.D., and W. J. MARQUIS, M.D., Newark, N. J.

The gastro-intestinal tract has been studied intensively by many different men from the roentgenological viewpoint. As a result, the accuracy of roentgen diagnoses of lesions of the stomach and duodenum is very high. The colon also can, as a rule, be examined roentgenoscopically and a diagnosis given which can be depended upon. Recently the small intestine has received intensive study by roentgenologists and lesions formerly overlooked are now being recognized. The oesophagus has not apparently received as careful study as the other parts of the gastro-intestinal tract.

Ernst states that Rumpel in 1897, using the fluoroscope, was the first to describe the roentgen appearance of idiopathic cardiospasm. In 1898, according to Heacock, Reitzenstein was probably the first to employ the roentgen ray in the diagnosis of a deep-seated diverticulum. The oesophagus was, therefore, one of the first organs in the body to receive roentgenological study but its location has prevented as thorough and intensive study as the remainder of the alimentary tract. It is not readily accessible to surgical exploration and although it can be readily examined by direct vision by means of the oesophagoscope, men trained in the use of this instrument are not very numerous.

Another factor that has hindered intensive studies of the oesophagus is the well-known observation that seldom does one see patients very early because symptoms do not become severe enough to alarm the patient sufficiently to consult a physician until the lesions are well advanced. The roentgenologist should, therefore, make a very careful search for lesions in any patient that presents symptoms referable to this organ.

In consulting the literature, one finds that studies of the lesions of the oesophagus are rare. Carmen and the Cole Collaborators have reported probably the most systematic studies in the English lauguage. It is difficult to make such studies because of difficulties in following the cases to determine end results. One has to resort mainly to clinical findings and oesophagoscopic observations. Although there are not many observations reported on lesions of the oesophagus as a whole, there are many reports of case histories or studies in regard to a certain lesion.

From a short review of the literature one finds that cases demonstrating the following lesions have been reported:

Benign—
- Cardiospasm
- Ulcerations
- Strictures
- Congenital atresia
- Varices
- Diverticulae—
  - Traction
  - Pulsion
  - Traction-pulsion

Malignant—
- Carcinoma
- Sarcoma

Extrinsic—
- Pressure from surrounding lesions

The methods of roentgen examination of the oesophagus have become fairly well established. There are minor variations, but on the whole nearly everyone uses the combination of fluoroscope and roentgenograms. With the improvement in technic one can obtain better roentgenograms and with the improvement in apparatus the fluoroscopic examination becomes easier.

The fluoroscopic examination may be made either with the patient in the horizontal or vertical positions. Preferably both positions should be, but probably seldom are, used. Usually a barium capsule is given and its course through the oesophagus is watched under the fluoroscope. Some men prefer a barium bougie. After the observation of the barium capsule, a barium mixture is given, the viscosity depending upon the behavior of the barium capsule. Roentgenograms are then made preferably in the horizontal position. We have found that with the patient on his back or in the left posterior oblique position, if four spoonsful of a fairly thick barium mixture are given as fast as the patient can swallow, the entire oesophagus can be visualized. Exposures are made in one-tenth of a second in order to minimize lack of detail due to the transmitted movement from the pulsation of the heart and great vessels, and peristalsis. We have not found it necessary to make the exposure at the end of expiration as recommended by some authors.

In this study an attempt has been made to analyze roentgen examinations made upon a group of fifty individuals. No attempt has been made to present an exhaustive clinical report. However, a few pertinent clinical facts have been given as shown in the accompanying table. Included in the table is the roentgen diagnosis. It will be noted that diaphragmatic hernia is listed, there being four cases in which this diagnosis was made. This is because in these cases the presenting symptoms were such that the clinician was led to believe that a lesion of the oesophagus was present. Thus in an examination of the oesophagus one should always be on the look-out for gastric herniation, which may take considerable time and patience to demonstrate, as it was in case No. 3218 who was examined several times before the lesion was found and afterwards when the lesion did not appear.

One case each of foreign body and carcinoma of the larynx are included. The foreign body consisted of a large piece of meat which had been swallowed. Without the clinical history the roentgen findings might have been misleading as there was a marked filling defect which persisted during the examination, and suggested some other type of lesion. In carcinoma of the larynx there may be involvement of the oesophagus and at times it is very difficult if not impossible to demonstrate this involvement. The case presented was a white man, age 58 years, who had complained of pain on swallowing for three months. The examination was made to rule out involvement of the oesophagus as direct inspection by the bronchoscopist with the laryngoscope showed definite carcinoma of the larynx. During the fluoroscopic examination the barium never entered the larynx or trachea, although the patient had great difficulty in swallowing, the barium apparently irritating the larynx and causing a great deal of coughing. There was no definite involvement of the oesophagus after once the barium had entered it.

No proven cases of ulceration are included. It would seem that ulceration should occur readily when one considers the abuse to which the average oesophagus is subjected. Yet authentic cases of ulceration not occurring as

the result of escarotics, in diaphragmatic hernia, marked cardiospasm, or advanced malignancy are exceedingly rare. Aurelius reports one such case. In our series we had one case in which a tentative diagnosis was made. However, except for the clinical findings it was not substantiated. An oesophagoscopy was not done. A second case was reported by the oesophagoscopist as an ulceration on the posterior wall in the upper third. An x-ray examination made elsewhere was suggestive of a malignancy in this region. The man recovered under treatment. An x-ray examination at this later time showed no pathology.

There were four cases of stricture due to scar formation following the swallowing of an escarotic, usually lye. These cases seldom present any difficulty in diagnosis because of the definite history present. However, occasionally one may examine a patient in which the history is concealed, and if the patient is an adult, the differential diagnosis may be very difficult.

A diverticulum was found in five patients. In three, the diverticulum was of the pulsion type, two being in the lower third and one in the upper third. Although having the usual wide mouth found in this type as contrasted with the narrow mouth of the pulsion type, this diverticulum retained the barium very well. The last case of this group showed multiple diverticula and also diverticula of the duodenum and the bladder.

The two largest groups were carcinoma with 14 cases and cardiospasm with 11 cases. The accompanying table shows that the age in the first group was 46 to 71 years, while in the cardiospasm group it was 48 to 80 years. Nearly all complained of difficulty in swallowing. The duration of symptoms was longer in the cases of cardiospasm.

One individual with carcinoma complained of pain in the epigastrium on swallowing food. An exploratory operation was done with a tentative diagnosis of a lesion in the stomach. After recovering from his operation, an examination was made of the chest and oesophagus. At this time the carcinoma of the oesophagus was found and he died about six weeks later. There are three cases in which a diagnosis of carcinoma was made in which the filling defect is perfectly smooth in outline. In two of these cases oesophagoscopy failed to verify the diagnosis and in the third case, no other examination was made. However, in one case there is evidence of metastases in the lungs probably from an old breast carcinoma and this patient is receiving high voltage roentgen therapy at present. One of the other two has had a course of deep x-ray therapy with little improvement. The third case appeared clinically to be malignant and no further information was available.

There was one case grouped as unknown in which there is a smooth filling defect similar to the above mentioned cases but in which the clinical symptoms were indefinite.

The seven remaining cases of this series of fifty patients examined were called normal.

One case grouped under cardiospasm showed a very unusual type of peristalsis. The waves were very active, passing rapidly upwards and downwards. The capsule was retained in the upper part for several minutes. Then it would pass toward the cardia only to be returned to the upper part again. A thick barium mixture did not pass into the stomach during the course of the examination, which lasted for ten or fifteen minutes, and during all this time waves of peristalsis passed back and forth.

Another case which was difficult to classify showed moderate dilatation and yet no definite delay was observed to occur in the passage of the barium into the stomach. A barium capsule, however, remained in the upper two-thirds of the oesophagus for some time. In the oesophagoscopic examination no spasm of the lower end of the oesophagus could be demonstrated. Therefore, it was felt that the lesion was a diffuse traction diverticulum. Roentgenologically, however, it resembles cardiospasm and has been so grouped with reservations.

SUMMARY

The roentgen diagnosis of lesions of the oesophagus is usually relatively simple but may be very difficult. The differential diagnosis of carcinoma of the lower end of the oesophagus and cardiospasm and diverticulum

at the lower end or diaphragmatic hernia usually gives the greatest difficulty.

There is a group of cases showing a moderate delay in the passage of the barium through the oesophagus, which is difficult to properly evaluate. This delay may possibly be due to early cardiospasm or may be a neurogenic condition similar to spastic colon.

It seems strange that ulcers are so rare in view of the fact that the oesophagus is exposed to much abuse by hot, cold and irritating foods. Perhaps in the future intensive studies of the oesophagus simliar to those of the stomach will show that ulcerations are of more frequent occurrence. This may explain the cause of some cases of heartburn, epigastric distress, etc., which at present are not evident.

TABLES SHOWING VARIOUS CLASSIFICATIONS OF 50 CASES

Normal	7
Carcinoma	14
Cardiospasm	11
Stricture	4
Ca. larynx	1
Diverticulum	5
Diaphragmatic hernia	4
Ulceration	2
Foreign body	1
Unknown	1

Carcinoma (largest group)—

Age 46-78.
C. C. dysphagia, 5 weeks to 7-8 yrs.
3 cases showed smooth defect
1 case near lower end
1 unknown, probably ca., might be cardiospasm

Cardiospasm—

Age 48-80 years, not known in four cases.
Usually dysphagia but several vomiting.
3 cases doubtful, no real spasm, only delay with evidences of irritable oesophagus. One case, marked.
Reverse peristalsis. 1 case.

Diverticulum—

Age 45-65. Three dysphagia. One, regurgitation. Two, pulsion on upper third. One, pulsion on lower third. One, traction, middle third. One, multiple.
Another case looked like cardiospasm but on direct inspection seemed to be due to diffuse diverticulum.

Diaphragmatic Hernia—

All complained at times of dysphagia.
Appearance very similar to diverticulum at lower end.
May have to make repeated examinations.

Stricture—

History usually makes diagnosis.
Occasionally may be difficult, then requires repeated examinations.

Ulceration—

1 case very questionable.
1 case reported by oesophagoscopist but not x-rayed until well.

Foreign Body—

1 case large piece of meat caused filling defect.

Ca. Larynx—

Secondary involvement of oesophagus may occur. Not able to demonstrate it.

Our thanks are extended to Dr. H. B. Orton for his help and courtesy in furnishing the reports of the oesophagoscopic examination.

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STATE SOCIETY ACTIVITIES

THE ANNUAL MEETING

The next Annual Meeting of The Medical Society of New Jersey will be held on April 30 and May 1 and 2, 1935, in Haddon Hall, Atlantic City, in accordance with the action of the House of Delegates and the Board of Trustees. The unusually early date of the meeting is made necessary by the fact that the American Medical Association will hold its annual meeting in Atlantic City on June 10-14. Past experience has shown that the meeting of the State Society is not affected by that of the A. M. A., provided there is a month's time between the two.

A joint conference of the members of the State Committees on Program and Arrangements, and Scientific Program, with the officers of the State Society was held on November 25, 1934, and tentative plans of the Annual Meeting were made. It was decided that the general outline of its events should be that of preceding years, with minor changes based on past experience, especially that of last year.

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

The first annual meeting of the Conference of Allied Medical Professions of New Jersey, composed of representatives from the state organizations of physicians, dentists, nurses and pharmacists, was held in the Executive Offices of the State Medical Society; Trenton, N. J., on December 12, 1934, with a full representation from each of its constituent groups. (For minutes of the organization meeting held September 12, 1934, see this Journal, October, 1934, page 604.)

The Chairman, Dr. Thomas K. Lewis, of Camden, called the meeting to order at 2:45 p. m.

The Secretary, John S. Owens, D.D.S., stated that each participating society had suggested key men in each county who would be active in forming county branches of the Conference.

The Conference then discussed legislative matters in which each group is interested.

For the Dental Group, Dr. C. P. Crowe, of East Orange, reported that the Dental Society is interested in a bill to permit compensation under the E. R. A. act to be paid to dentists already employed by municipalities, as is allowed to physicians by the bill passed last winter.

Dr. D. Leo Haggerty reported that the major piece of legislation contemplated by the Medical Society is the Uniform Medical Practice Act, which would apply to all persons following any form of medical practice.

Miss Anna Ewing, of Newark, legislative representative for the Nurses' Group, reported that legislation is proposed to establish qualifications in nursing positions.

Dr. Robert P. Fischelis, Ph.D., reported on a proposed bill to empower the State Board of Pharmacists to maintain criminal proceedings against chronic violators of the Pharmacy Act. This law would reach those who consider fines as public contributions for the privilege of continuing their violations of the law. This proposition was referred to the legislative committees of each of the four groups in the Conference.

Dr. Fischelis mentioned a bill to require each graduate in pharmacy to have one year of practical experience under a licensed pharmacist before he can enter upon the independent practice of pharmacy.

Dr. Fischelis also mentioned the proposed law that licensure fees shall be held and dispensed by the several professional boards, instead of being turned into the State Treasury and disbursed by legislative enactment. The conference voted to promote the legislation.

Dr. Lewis read a communication from Dr. F. E. Elliott, Chairman of the Committee on Economics of the New York State Medical Society, relative to proposed legislation for social insurance. After a discussion relating to this subject, in which Dr. Nichols, Dr. Wilkes, Dr. Lewis and Miss Seifert took part, a motion was made by Dr. Nichols that the Conference go on record as requesting that the

State and National representatives of our four professions in the Allied Conference be recognized and have a definite part in the formulation and direction of any plans which are intended to provide better medical care, and that adequate opportunity for the consideration and assistance to be given by these four groups be provided for sufficiently far in advance of their passage as to provide adequate time for careful consideration and criticism. This motion was seconded and unanimously carried.

Dr. Nichols stated that, in the Public Health Hour project, efforts to acquaint parents with the opportunities which it provides are made in three ways:

1. By letters to families from their family physician.
2. By nurses' follow-up of Dr. Levy's survey of non-immune preschool children. (Journal, June, 1934, page 356.)
3. By the preschool age supervision of the physicians.

Dr. Nichols stressed the great value of the nurses' groups in the preschool-age program, and asked for endorsement and coöperation from the conference groups either formal or informal, in the Public Health Committee's program for better medical services, especially those for children. This endorsement was unanimously given.

In conneciton with the Emergency Relief project, Dr. Nichols emphasized the point that a medical representative should be on every E. R. A. County Administrative Council and, if possible, a representative of each of the four divisions of medical service represented in the Conference, since a large part of the work of relief has to do with consideration in which these four groups have the most extended knowledge and experience.

Miss Fisher moved that the County Administrative Council be urged to have a representative of each organization in the Conference of Allied Medical Professions placed on the Advisory Committee of each County Administrative Council. This motion was seconded and unanimously approved.

Miss Fisher suggested that rules and regulations for the guidance of Conference representatives in the counties be formulated.

The following officers were elected:

President, Robert P. Fischelis, Ph.D., Trenton.

Vice-President, John S. Owens, D.D.S., Camden.

Secretary-Treasurer, D. Leo Haggerty, M.D., Trenton.

PROMOTING THE PUBLIC HEALTH HOUR

To Our Fellow-Members of the State Medical Society:

In order to make our Diphtheria Immunization of the preschool children effective, it is now necessary for our Public Health Committee to ask each member of the Medical Society of New Jersey to undertake *certain definite things at once.*

First, we are asking each one of you to write a letter to the parents of every child between the ages of six months and six years, obtained from the lists on your office records, or by consulting the stubs of the past six years on birth reports of babies you have delivered. It is suggested that in this letter you state that the Department of Health has requested you to immunize all children under your care at once; also that you are writing the letter in compliance with this request, naming a definite time at which you would like to do this immunization (naming the child) in your office. (See Editorial, page 6.)

In other words, we wish each member of the State Society to *engage at once* in doing his part toward the *recovery program* which is designed to bring the practice of public health and preventive medicine back to the doctor's office by this procedure.

The Public Health Committee of your County Society has been urged to get the nurses, Boards of Health, Schools, Parent-Teachers Associations, and other groups into action in order to assist in getting children to your office for immunization and vaccination; but the *primary responsibility for your own patients rests with you.*

We have asked the Editor of the State Journal to print a monthly record on a Public Health Page in the State Journal showing for your county how many doctors have signed up, how many have taken out free toxoid and vaccine, and how many immunizations and vaccinations are being done monthly. The toxoid is available, and between now and May first we must make a fine showing, if we are to prove that organized medicine *can assume* public health leadership and do a health job *well.*

It is up to *each one of you personally.* May

we suggest that you get in touch with the Public Health Committee of your County Medical Society and give it your best personal coöperation in this matter.

With our best wishes for a New Year full of recovery for each doctor in his private office and all phases of public health and preventive practice, I wish to remain

Fraternally yours,
STANLEY NICHOLS, *Chairman*,
Public Health Committee,
Medical Society of New Jersey.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS

County	DIPHTHERIA TOXOID				SMALLPOX VACCINE			
	To Oct. 31st	Average per month	Month of November	Total to Nov. 30th	To Oct. 31st	Average per month	Month of November	Total to Nov. 30th
Atlantic	8	2.	0	8	18	4.5	88	106
Bergen	290	72.5	530	820	194	48.5	170	364
Burlington	0	0	0	0	39	9.7	0	39
Camden	20	5.	7	27	94	23.5	2	96
Cape May	12	3.	8	20	27	6.7	9	36
Cumberland	41	10.2	2	43	17	4.2	2	19
Essex	131	32.7	372	503	193	48.2	264	457
Gloucester	143	35.7	22	165	129	32.2	61	190
Hunterdon	5	1.2	40	45	2	.50	37	39
Mercer	0	0	3	3	0	0	19	19
Middlesex	567	141.7	83	650	356	89.	44	400
Monmouth	86	21.5	18	104	9	2.2	12	21
Morris	34	8.5	24	58	66	16.5	40	106
Ocean	4	1.	4	8	10	2.5	0	10
Passaic	225	56.2	189	414	305	76.2	66	371
Salem	9	2.2	4	13	3	.75	2	5
Somerset	6	1.5	316	322	2	.50	85	87
Sussex	14	3.5	2	16	0	0	0	0
Union	85	21.2	21	106	18	4.5	6	24
Warren	25	6.2	2	27	87	21.7	4	91
Totals	1705	426.2	1647	3352	1569	392.2	911	2480

THE NEW JERSEY CONFERENCE OF SOCIAL WORK

The thirty-third annual New Jersey Conference of Social Workers, to which reference was made in an editorial on page 672 of the December Journal, was held in Asbury Park on December 7 and 8, 1934. About 1000 persons were present, representing the state-wide social and welfare groups, such as the Tuberculosis Association, the Emergency Relief Administration, family welfare workers, staff members of state institutions, county and municipal investigators, and executives of child-caring institutions.

About thirty physicians were also present representing The Medical Society of New Jersey, at the suggestion of President Ely, in order to observe the proceedings and learn the point of view of the social and welfare workers.

The Conference was officially opened by the President, Edward C. Lindeman, Professor

of Social Research in the New York School of Social Work, who outlined the way in which the Conference was to be conducted. His main theme was an emphasis on his belief that "Social Security" can only be achieved by an intelligently planned program. Dr. Lindeman seemed to attach little importance to the influence of emotions as a motivating force in changing the best-laid plans.

Each half day's program began with a general assembly, which was addressed by a selected speaker of prominence. The conference then divided itself into small groups of thirty members for the purpose of discussing the points developed in the main conference. The groups on the first day were formed around prominent authorities, such as J. Douglas Brown, from the Department of Economics of Princeton University, and Mrs. John Hawes, Director, Bergen County Emergency Relief Administration.

The groups on the second day were arranged according to subjects, such as children, community organizations, the family, health, and housing.

The agreements reached by each smaller group were recorded by a "reporter"; and near the close of the Conference, the entire proceedings were reviewed by Dr. James S. Plant, psychiatrist to the Child Guidance Clinic of Newark, in a practical effective way.

There were three main divisions of the general topic on Social Security:

a. What interferes with security?
b. How shall we achieve security?
c. What is the rôle of social work for achieving security?

An outstanding address in the general session was that of Dean Kenneth L. Pray, of Philadelphia School of Social Work, who outlined the sound principles of the activities of the Social Groups.

Commissioner William J. Ellis presided at the banquet, at which Mr. Lewis Compton spoke on "Future Plans of the E. R. A.", and Aubrey Williams on those of the F. E. R. A. Dr. Williams offered a rather discouraging outlook, with ambitious plans for immediate attack.

Dr. Plant's excellent summary was briefly as follows:

Dr. Plant stated that a study of the trends of the present and past conferences of the New Jersey Conference on Social Work indicate that an undue amount of interest has been shown in the past on the influence of the environment as it affected the security of the people of this State; whereas the real problems lie on the people themselves as reflected from the economic dislocations which underlie the present depression.

Dr. Plant emphasized his belief that the chief outcomes from the New Jersey Conferences on Social Work, past and present, lie in the increased breadth of view of the participating individuals who come together to exchange ideas and suggestions for increasing the social security of the people in their individual communities. In connection with this suggestion, he quoted from a Greek philosopher, "I know that I can never learn what I have been taught."

Dr. Plant stated that most of the discussions centered on insecurity, and were the results of studies on people who were socially insecure. He believed that, in order to determine ways and means of increasing the social security of individuals, more studies should be made on *socially secure* persons in order to ascertain the methods by which they attained security. These studies should center on the duties of the insecure persons themselves, as well as manipulations of the environmental conditions without reference to the mental and emotional attitude of the needy persons.

In commenting on the proposal to appoint groups in each community to promote the suggestions of the Conference, he felt that the use of such groups as "Pressure Groups" was not nearly so desirable as to use such groups as a forum; through the discussions of each group these persons might first find the answers to their own problems through self study prior to the formulation of ideas which such groups had found, by actual experience, were successful in promoting their own social security.

Dr. Plant stated that the *example* set by the members of such forum groups, rather than the precepts they expound, would be the factor which would determine the achievements that they might hope to accomplish.

He stated that there had been much discussion directed toward the redistribution of wealth. It is his belief that the redistribution of wealth would accomplish its intended purpose only when the proper use of such redistributed wealth had first been assured through study and experiment.

Dr. Plant emphasized the belief that work alone was not the sole answer to the problem of securing happiness. He cited the fact that some provision must be made for assuring a certain amount of happiness to old persons in spite of the fact that they had passed the age when work either could not be obtained or accomplished. For those persons he advocated

a program of old-age pensions. Such provisions, he believed, would be economical and practical of application, and probably offer the best first approach to the larger problem of social security for all.

Social insurance and unemployment insurance are much more complicated problems, and require further study and experiment to determine economical and effective ways and means to provide for their practical operation.

LeRoy A. Wilkes,
Executive Secretary.

EMERGENCY RELIEF ADMINISTRATION

Minutes of the Meeting of the E. R. A. State Advisory Committee in Newark on December 4th, 1934, at 4:15 p. m., at E. R. A. Headquarters.

Those present were: Dr. Snedecor, presiding; Drs. Schlichter, Fithian, Hawkes, Sherman and Tooker, Mr. Colman, and Dr. Wilkes, Secretary.

UNION COUNTY PLAN FOR SALARIED E. R. A. PHYSICIANS

The committee discussed the Union County Relief Committee proposal to engage ten salaried physicians to care for the medical relief cases. The political aspects of the proposal were emphasized by Dr. Schlichter and after a discussion the proposal was unanimously disapproved by the Committee.

Mr. Coleman, of the E. R. A., expressed his conviction that medical care provided by salaried physicians was rarely equal in quality to that provided by private physicians paid on a fee basis. He pointed out that the Union County proposal indicated one of the dangers inherent in the proposed decentralized control of relief.

Mr. Coleman stated that the law under which the E. R. A. was now operating terminated automatically on January 31, 1935, and no intimation had been given as to whether the present plan would be continued after that time or whether a new set-up would result.

The opinion of the State Medical Advisory Committee to E. R. A. is that the action of the committee in recommending the present plan for E. R. A. be continued, should be further discussed with the Welfare Committee and that a meeting of the Welfare Committee should be urged as early in January as possible.

Dr. Snedecor and Dr. Wilkes were instructed by the committee to draft a letter to the State Administrative Council stating that it is the sense of the State Medical Advisory Committee that:

1. The judgment of the Union County Administrative Council that the service under the proposed plan of salaried physicians would maintain the quality of service now rendered, should be challenged.

2. The actual cost of E. R. A. medical relief under this plan would not reduce the cost of medical care due to anticipated increased hospitalization cost.

3. The plan would deny free choice of physicians, and cause former private patients to return to their family physician with a demand for free treatment; and this would add to the burden of the private physicians, who would be denied the fees agreed upon in the E. R. A. agreement.

The Union County Medical Society recorded its attitude against such a change at the meeting held on December 5th in Elizabeth.

RESOLUTION OF APPROVAL FOR RENEWING E. R. A. AGREEMENT

The State Advisory Committee passed the following resolution, that the Executive Secretary of the State Medical Society call to the attention of President Ely and the Chairman of the Welfare Committee the resolution of the State Medical Advisory Committee, which urges the continuation of the E. R. A.-Medical Society agreement as being, in the opinion of the Committee, satisfactory to the majority of the members of the organized medical profession of New Jersey.

This resolution was as follows: "Resolved, that the State Medical Advisory Committee to the E. R. A. believes from the experience of the members and their contacts with individual physicians participating in the work, that the majority of the County Medical Society members coöperating in the medical care for indigents' project, under the present agreement and plan, wish the agreement and the present plan for indigent medical relief continued with certain changes, because in their opinion, the plan has proven to be practical and effective as an emergency measure, in spite of its many shortcomings."

The committee feels that this approval should be made known to Governor Hoffman, Senator Wolber and the other members of the legislative committee on the revision of the Law for Emergency Relief Administration.

CIVIL WORKS ADMINISTRATIVE PROJECT BILLS FOR SERVICES RENDERED

The Chairman, Dr. Snedecor, informed the Advisory Committee members of the C. W. A. reply from Washington regarding the claim of arbitrary reduction of charges made as in agreement with the plan proposed. The reply stated that a representative of the C. W. A. from Washington would, upon request, meet with the Medical Advisory Committee of the State E. R. A. Dr. Snedecor was instructed to arrange for such a conference.

E. R. A. AUTHORIZATION DATES

The committee next discussed the question of time limits to be recognized on official authorization blanks. The point was emphasized by the E. R. A. members that the vital issue was the date upon which the doctor informed the E. R. A. County Office, and that this report must be made by the doctor within forty-eight hours from the time the treatment was given. Authorization by the E. R. A. office may then be delayed without penalty on the part of the physician.

OUR GROUP ACCIDENT AND HEALTH, AND AUTOMOBILE INSURANCE

A LETTER FROM THE COMMITTEE ON INSURANCE

To the Members of the Medical Society of New Jersey:

At the last convention of the Medical Society of New Jersey, June 1934, the *Committee on Insurance* made its eighth annual report to the Society (see Journal, May 1934, page 273). This report represented about ten years of study of this somewhat intricate subject, which has importance to every physician since insurance covers his means of livelihood depending upon his professional work. The insurance policies are all unique in that they have been especially negotiated by us for the benefit of our members. They are not merely standard policies written by companies for others, but are especially designed for our members only, this being achieved under the law, which is stringent on equality of provisions, but possible through better service by the agencies.

The past year was outstanding in two ways: 1, The increase in number of policy-holders, this being especially remarkable in the automobile insurance; and, 2, the warm approval, volunteered by members, of the service received in the adjustment of their claims. This approval is most satisfactory to the committee because it reveals that our object of profitable service to them has been appreciated. This approval applies to almost every single claim, the only exceptions being one or two with initial differences of judgment on degree of disability—and these were amicably adjusted through the offices of the committee according to the important part of our contract whereby the committee must be consulted in any differences between a member and the company.

The committee feels great responsibility in recommending any insurance policy to the members, but is warranted in doing so by the record of our companies on financial stability, conservative management, and record of service rendered, all this information being furnished by both the State Departments of Banking and Insurance, and also the Alfred M. Best Company, which functions for insurance as Dun & Bradstreet do for other business. Furthermore, the Trustees of the State Society, through a special committee including four past presidents, investigated the contracts and the reliability of the companies, and recommended them very highly. All our members may feel assured that, through the studies of the Committee, the reports of the Trustees, and the records of the companies, the Society has left nothing undone for insurance security. We gladly refer, by permission, to Past President Quigley and to President Ely.

ACCIDENT AND HEALTH POLICY

The policy covering accident and health is written by the National Casualty Company of Detroit. It is the identical policy originally negotiated years ago and is modified only because we desired to make a better definition of "house-confinement", and to incorporate it in every member's certificate instead of leaving it for negotiable adjustment. Another advantage was increase to six weeks, instead of four, of the period for partial disability from sickness.

The principal sum is $5000 for loss, by accident, of life, or both hands, or feet, or eyes; $2500 for loss of one hand or foot; and $1500 for loss of one eye.

For total disability from accident the insurance is $50 weekly for 52 weeks; for partial disability from accident $25 weekly for 26 weeks.

For total disability from sickness (house-confining) $50 weekly for 52 weeks; for total disability from sickness (not house-confining)

$25 weekly for six weeks (this being more liberal than formerly, house-confining for four weeks).

All the above indemnities are doubled for "travel" accident, i. e., principal sum $10,000, and weekly sums of $100 for total, and $50 for partial disability. Travel accident is agreed to include "public vehicle licensed for regular transportation of passengers" including passenger elevators, taxicabs, etc., and, by a recent further negotiation, air-planes on regular scheduled routes and operated by duly licensed aviators—this with no additional premium.

Claims are paid within thirty days.

Notice of accident must be given within 20 days; of illness within 10 days; and of death immediately.

No medical examination is required. All members of the State Society in good standing and repute are eligible, provided they are in good health and free from injury.

the risk covered; injuries intentionally self-inflicted; and intentional self-poisoning.

The premium must have been actually paid in order that the policy shall be in force.

In our experience the settlement of claims by the company is eminently prompt, fair, and considerate without resort to technicalities; and is notable in the manner of adjustment and the ready reference of any disputed matters to our committee for adjudication.

We urge every member to read his policy and to know just what it covers.

We therefore call your attention to the following notable reasons for your carrying this policy:

The broad range of contingencies in a doctor's life which are covered;

The unequalled low rates of premium;

The substantial character of the company as rated by the Departments of Banking and Insurance;

PREMIUM RATES	*Regular Policy* ($50.00 Weekly Benefit)		*Special Policy* ($25.00 Weekly Benefit)	
	Monthly	Semi-annual	Annual	Annual only
Ages up to 50, next birthday	$5.60	$31.20	$60.00	$35.00
Ages 51 and under 60, next birthday	6.55	36.40	70.00	40.00
Ages 61 next birthday and over	7.95	44.20	85.00	47.50

Regular Policy	BENEFITS	*Special Policy*
$50.00	Weekly, Accident or Illness	$25.00
$100.00	Weekly, Public Conveyance Accident	$50.00
$5,000.00	Ordinary Accidental Death Benefit	$5,000.00
$10,000.00	Public Conveyance Accidental Death Benefit	$10,000.00

Other Features. All as Shown in Policy.

The Agency is E. & W. Blanksteen, 76 Montgomery Street, Jersey City, New Jersey (Tel. Bergen 4-6051).

The policy is non-cancelable for the policy year when paid for. It is renewable if the company's experience on the group is not unfavorable.

Any change in rates or terms, and any "acceptance or rejection or renewal of membership will be referred to the Society" (not arbitrarily determined by the company).

The benefits under the policy are not contingent upon, nor affected by, any other insurance carried by the holder.

Not covered are: the first seven days of disability from either accident or illness; venereal disease not innocently acquired in the practice of medicine; operations for chronic or preëxistent ailments; racing; aviation other than as a passenger, as above included in

The agreeable manner of the manager and agency in dealing with our members;

And, finally, the unique advantage of an intermediary in any case of difference between policy-holder and company—this intermediary being your own State Society, through this committee, admittedly representing the policy-holder in his behalf.

Note that the policy, when paid for, is secure under all circumstances to the next renewal date; that renewal cannot be denied without reference to the Society; and that a receipt from either the agent or the company for premium paid, or your paid check, is perfect security.

Besides the regular policy we have arranged for a special policy at one-half the benefits,

also for fractional premiums enabling you to pay, at your choice, annually, semi-annually, or even monthly. The following table exhibits these advantages:

AUTOMOBILE INSURANCE

"Liability and property damage" is covered by the Manufacturers Casualty Insurance Company of Philadelphia, under a standard policy, at a discount to our members of 15 per cent, plus a dividend at the end of the year, which has not been below 15 per cent for many years. The company's rating is among the highest of the insurance companies, and its standing with the Commissioners of Banking is excellent.

The law on "financial responsibility" of drivers is very important and though not "compulsory insurance" makes insurance almost imperative. But this does not secure innocent victims of accidents against a reckless or drunken driver. Here is where our group policy has an advantage over any other policy whatsoever, the agency agreeing to handle any case of accident in which our member has claim against the other party, the agreement covering all the services of investigation, negotiation, and adjustment, even legal advice and law-suit if necessary, without expense to our member or increase of premium. This is a most remarkable and unusual provision, besides the advantages of low rates and full coverage under the policy itself with all the standard provisions.

The policy on "Fire and Theft, Collision and Transportation" is written by a collateral company under the same management and agency. It is a "valued" form, which means one naming the value of the car insured and which holds without reduction throughout the year, therefore insuring for a definite amount. The premium is at a discount to our members of 20 per cent from the standard tables. The owner of a second car is offered insurance covering it at a premium of a small fraction of that for the first car—a marked saving to those having more than one car. This is all managed by the Way Agency, 605 Broad Street, Newark, New Jersey (room 705, Tel. Mitchell 2-0613). This agency has made a most remarkable record in increase of business the past year, the number of policyholders noted in our report of 1933 being 533, which increased in one year to 953 last June, and now to nearly 1200. We have, therefore, the decided advantage of having one company and one agency handling all our Automobile Insurance.

CONCLUSION

One thing is emphatically called to your attention. Letters to you from the agencies, and mention of them in the County Society Bulletins are too often ignored, so that the members by their neglect remain in ignorance of the advantages of their membership in the Society and of the special privileges in insurance. Read your mail! You pay your dues. Why not make use of what you pay for?

The Committee on Insurance

Frank W. Pinneo, *Chairman.*

HEALTH LEGISLATION

When the first meeting of the Federal Advisory Council on Social Security was opened on November 14, 1934 (Jour., Nov. 1934, p. 651), President Ely sent the following telegram to Secretary Perkins, Chairman of the Committee:

"The policy of The Medical Society of New Jersey is that, in any medical program for the benefit of the indigent and those in the low income group, the planning and conducting of the work in each state should be in the hands of the medical agencies which were founded primarily for health service, such as the State Medical Society and the Department of Health. The Medical Society of New Jersey is now operating practical projects conforming to this policy and to the ten principles enunciated by the American Medical Association. It is our opinion and we urge that these general policies should be carried out."

On December 12, 1934, the New Jersey Conference of Allied Medical Professions, representing the Medical, Dental, Nursing, and Pharmaceutical Societies, adopted the following resolution:

"That the Conference go on record as requesting that State and National representatives of the four professions in the Conference of Allied Medical Professions be recognized and have a definite part in the formulation, direction, and control of any plans which are intended to provide better medical care for the people; and that adequate opportunity for the consideration and assistance to be given by these four groups be provided for sufficiently far in advance to the passage of any legislation as to provide adequate time for careful consideration and criticism."

Copies of the letter and the resolution have been sent to federal and state legislators, officials and executives, including President Roosevelt. The leaders of The Medical Society of New Jersey are always ready to advise on any health legislation that may be proposed.

FORMULARY FOR NEW JERSEY

FIRST ARTICLE

The general economic situation and the specific problems arising in connection with the practice of medicine under Federal and State Emergency Relief have focused attention upon the quality and costs of medicines. Under the regulations of the Emergency Relief Administration only United States Pharmacopoeia and National Formulary drugs and medicines may be prescribed, unless no satisfactory *official* remedy exists to provide the therapeutic action desired by the physician.

The principles which apply to medical practice under Emergency Relief are applicable with equal force and advantage to general practice. It has become a habit with many physicians to prescribe proprietary mixtures for conditions which can be treated just as satisfactorily, and possibly more so, by means of an extemporaneous prescription consisting of a combination of official drugs and preparations written to fit the case, and possibly better fitting the pocketbook of the patient.

The U. S. Pharmacopoeia and the National Formulary are revised every ten years. In the interim many new drugs are developed. They appear as "non-official" remedies and the annual volume of "New and Non-official Remedies" published by the American Medical Association is an invaluable source of information on accepted products. However, it does not pretend to indicate to the physician how these new remedies shall be combined for administration in combination with other drugs.

Herein lies an opportunity for coöperation between the medical and pharmacal professions which has struck a responsive chord among the members of the Medical Society of New Jersey and the New Jersey Pharmaceutical Association. Early in 1934 the Committee on Professional Relations of the latter pharmacists and the Sub-Committee on Medical Practice of the Welfare Committee of the physicians met to discuss the general aspects of the problem and a basis for joint action was evolved.

The pharmacal group presented a series of well-developed formulas to the medical group, and at one of the meetings brought in actual samples of the preparations under discussion. The Committee on Medical Practice was favorably impressed and recommended coöperation between The Medical Society of New Jersey and the New Jersey Pharmaceutical Association in the development of a New Jersey Formulary. The advantages of such an undertaking may be listed briefly as follows:

1. Uniformity of dosage and flavor if a definite formula is evolved, and the product is designated by a descriptive name approved by the two professions.

2. Physicians will be provided with all the advantages claimed for proprietary products; and their patients may be saved some money because non-proprietary products of equivalent therapeutic actions are prescribed.

3. Lessened tendency to self-medication and counter-prescribing.

4. Encouragement and training of the medical profession in the use of U. S. P. and N. F. preparations and new remedies under their scientific names.

5. Encouragement of the pharmacist in the greater use of his professional knowledge and training.

To bring the plans of the two committees to fruition the two state societies of physicians and of pharmacists, endorsed the publication of a series of formulas approved by their respective committees. It is hoped that further progress will be made along this line, and that from time to time these approved formulas will be published in the Journal and reprinted for distribution to the professions. The Pharmaceutical Association has under consideration the matter of supplying a loose-leaf binder to physicians for filing these formulas in permanent form. Comment and suggestions are invited on this initial effort to launch a New Jersey Formulary.

NEW JERSEY FORMULARY

FIRST INSTALLMENT

These formulas are issued with the approval of the Committee on Medical Practice of The Medical Society of New Jersey, and the Committee on Professional Relations of The New Jersey Pharmaceutical Association, acting as a Joint Committee on a New Jersey Formulary.

ELIXIR PHENOBARBITALIS
ELIXIR PHENOBARBITAL
ELIX. PHENOBARB.

Phenobarbital, U. S. P.	4.00	Gms.
Alcohol	275.00	c.c.
Cudbear (Powd)	0.5	Gm.
Saccharin, Soluble	0.275	Gm.
Vanillin	0.135	Gm.
Oil Orange	1.6	c.c.
Oil Cassia	0.25	c.c.

Mix and allow to stand for a few hours and add—

Glycerin	300.	c.c.

Mix and then add in small portions, and with agitation after each addition—

Water to make	1000.	cc.

Filter, using Purified Talc sufficient to clarify.

Average Dose: Metric, 4 c.c.—Apothecaries fl3i. One average dose contains about: 0.016 Gms., or ¼ Gr. of Phenobarbital.

Alcohol Content: 26 per cent.

SYRUPUS POTASSII GUAIACOL SULPHONATIS
SYRUP OF POTASSIUM GUIAIACOL SULPHONATE
SYR. POT. GUAIAC. SULPH.

Potassium Guaiacol Sulphonate	100.00	Gms.
Aromatic Syrup Eriodictyon N.F.	500.00	c.c.
Aqua Destillata, a sufficient quantity to make	1000.00	c.c.

Dissolve the potassium Guaiacol Sulphonate in 475 c.c. of Distilled Water and add the Aromatic Syrup Eriodictyon. Add sufficient quantity of Distilled Water to make 1000 c.c.

Average Dose: Metric, 4 c.c. Apothecaries fl3i.

One average dose contains about 0.4 Gm. or 6 Grs.

PULVIS BISMUTH SUBCARBONATIS COMPOSITUS
POWDER OF BISMUTH SUB CARBONATE COMPOUND
PULV. BIS. SUBCARB. CO.

Bismuth Subcarbonate	14.3 Gms.
Oil Anise	0.46 Gms.
Saccharin, Soluble	0.24 Gms.
Calcium Carbonate, Precipitated	35.00 Gms.
Magnesium Carbonate, Light	50.00 Gms.

Mix lightly and sift two or three times through No. 60 sieve.

Average Dose: Metric. 1 Gm.; or Apothecaries 15 Grs.

Average dose represents approximately:
Magnesium Carbonate 0.5 Gms., or 7½ Grs.
Calcium Carbonate 0.35 Gms., or 5¼ Grs.
Bismuth Sub Carbonate 0.143 Gms., or 2 14/100 Grs.

When properly prepared 1 *level* teaspoonful equals approximately 1. Gm. N.B. This preparation should not be compressed by heavy trituration of the ingredients.

NEBULA EPHEDRINAE
EPHEDRINE INHALANT PLAIN
NEBUL. EPHEDRIN

Ephedrine, Alkaloid	10.0	Gms.
Oleic Acid	20.0	Gms.

Rub together and add after clear product is obtained.

Oil Rose Geranium	1.0	c.c.
Light Liquid Petrolatum sufficient quantity to make	1000.00	Gms.

Filter through paper.

This preparation may be colored a light salmon pink by addition of coarsely powdered Alkanet Root 1.25 Gms. before filtration, and maceration with frequent shaking during twenty-four hours, then filtering through paper.

Heat should be avoided in making this preparation.

Use as a spray.

NEBULA EPHEDRINAE COMPOSITA
COMPOUND EPHEDRINE INHALANT
NEBUL. EPHEDRIN. CO.

Camphor	5.0	Gms.
Menthol	5.0	Gms.
Ephedrine Inhalant, Plain sufficient quantity to make	1000.0	Gms.

Triturate Camphor and Menthol together till liquefied and add the Ephedrine Inhalant.

Filter if necessary.

Use as a spray.

Committee on Professional Relations
The New Jersey Pharmaceutical Association

William R. Richart, *Chairman*
George M. Beringer
Jacob Feinberg
Everett J. Gorman
John H. Hoagland
Joseph Kaden
George C. Schicks
Kenneth Weeks

Committee on Medical Practice
Medical Society of New Jersey
Thomas K. Lewis, *Chairman*
E. LeRoy Wood
H. B. Wilson
A. Anderson Lawton
Chester I. Ulmer

SCIENTIFIC EXHIBITS IN THE ANNUAL MEETING

The physicians of New Jersey made a notable contribution to the Annual Meeting of their State Medical Society at Atlantic City on June 5, 6 and 7, 1934, with scientific exhibits of high merit and of practical interest to all practitioners of medicine.

The exhibits filled two large rooms, which were special centers of attraction to all the members at the Annual Meeting. A valuable feature of the exhibition was the presence of the exhibitors themselves who interpreted the specimens and charts and explained their application to the practice of medicine.

Over forty exhibits were prepared and shown at the meeting of the State Society; and two weeks later several of the exhibits were taken to Cleveland to be shown at the meeting of the American Medical Association.

The Committee on Scientific Exhibits is planning to hold an exhibit this year as a major feature of the next Annual Meeting, which will be held in Haddon Hall, Atlantic City, April 30, and May 1 and 2, 1935. Six weeks later, on June 10-14, the American Medical Association will hold its annual meeting in Atlantic City. Physicians of New Jersey, therefore, have a double incentive to prepare scientific exhibits, for they may be easily shown at both meetings.

It is extremely desirable that clinicians and research workers make use of this unusual opportunity to display the results of their observations and research at both of the meetings. The Annual Meeting of The Medical Society of New Jersey will afford its members the opportunity to secure recognition for meritorious work by those who do not aspire to the scope and extent of a national exhibit.

The scientific exhibit at the Annual Meeting of The Medical Society of New Jersey will consist of a *General Exhibit,* and an *X-Ray Exhibit.*

SPECIFICATIONS OF THE EXHIBITS

The General Exhibit will include the demonstration of pathological and clinical material in the form of specimens, charts, photographs, models, etc. X-ray material used in the General Exhibit must be in the form of paper prints.

Space for the General Exhibit will be assigned by units. Each unit will consist of a booth 5 feet long, constructed with a base 18 inches deep, and a counter 30 inches high. The space above this counter is 4 feet high, divided in two sections each 2½ feet wide, and fitted with four removable or convertible shelves 7 inches in depth. Table space will also be available for certain exhibits.

Space for the X-Ray Exhibit will be limited to six rectangular viewing units equipped with Cooper-Hewitt lights.

All exhibits must be completely installed before 10 p. m. Monday, April 29; and must remain installed until Friday morning, May 3. Booths will be ready for occupancy Monday at noon.

APPLICATIONS

Applications for space in the exhibit of the State Society meeting may be made to the Chairman of the State Committee on Scientific Exhibit, Dr. John W. Gray, 142 Clinton Avenue, Newark, N. J.

An application blank is printed on the opposite side of this page. The entire sheet may be removed and sent to the Chairman. The blank forms will also be mailed to prospective exhibitors.

Applications must be received before March 1, 1935. They will be promptly acted upon by the committee.

Exhibitors will be assigned a specific time for daily demonstrations of their subjects.

It is desirable that each exhibitor shall display a brief, typed description of his exhibit; and that it be signed with his name and address for the convenience of visitors who may wish to correspond with him.

Applications for space in the A. M. A. exhibit may be sent to the director of the national exhibit, Dr. Thomas G. Hull, 535 North Dearborn Street, Chicago, Illinois.

John W. Gray, *Chairman.*

FORM OF APPLICATION FOR SPACE

1. Title of Exhibit .....

2. Description of General Exhibit (Number and character of specimens, charts, photographs, and models) .....

.....

.....

.....

.....

3. Number of booth units desired for General Exhibit (See accompanying description of units) .....

4. Will motion pictures be used in a booth as part of the exhibit? (Special equipment for such demonstration must be furnished by the exhibitor) .....

.....

5. X-Ray Exhibit (Number of cases. Number and sizes of films) .....

.....

.....

.....

.....

6. Will a paper be presented before the Session dealing with material exhibited? .....

.....

If so, mention its title .....

7. Has this exhibit been shown in whole or in part at a previous New Jersey State Meeting, or at any other scientific meeting? .....

If so, when and where? .....

.....

(Signature of Applicant)

Date ....

(Full Address)

The Committee on Scientific Exhibits will furnish *uniform*, *painted* signs for each exhibit. Please fill in the following blank *carefully*. This is for copy for the sign painter.

Title .....

Sub-title (if any) .....

Name of Exhibitor(s) .....

Institution (if desired) .....

City ..... State .....

Send applications to the Chairman of Scientific Exhibits, 142 Clinton Avenue, Newark, New Jersey.

Committee on Scientific Exhibits

JOHN W. GRAY, M.D., *Chairman*
HARRISON S. MARTLAND, M.D.
ELWOOD E. DOWNS, M.D.
ROBERT A. KILDUFFE, M.D.
ASHER YAGUDA, M.D.
WILLIAM J. MARQUIS, M.D.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

JANUARY, 1935				FEBRUARY			
1	Camden	10	Essex	5	Camden	13	Union
3	Hudson	10	Passaic	7	Hudson	14	Essex
8	Bergen	11	Atlantic	8	Atlantic	14	Passaic
8	Cumberland	15	Warren	12	Bergen	14	Somerset
8	Sussex	16	Middlesex	13	Mercer	20	Middlesex
9	Mercer	17	Gloucester	13	Ocean	21	Gloucester
9	Ocean	22	Hunterdon	13	Salem	27	Monmouth
10	Burlington	23	Monmouth				

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The Annual Meeting of the *Atlantic County Medical Society* was held in the Japanese Room of the Hotel Ambassador on December 14, 1934, at 8.30 P. M.

The Secretary read a letter from Dr. S. A. Brumm, the President of the Philadelphia County Society assuring us of the coöperation of that Society during the coming A. M. A. meeting.

A letter from the A. M. A. was read announcing that reprints on the subject of sickness insurance were being sent for the information of our members. These reprints were on the table and the Secretary announced that members wishing them should take them after the meting.

A letter from Dr. A. D. Hutchinson, Secretary of the Conference of the County Secretaries and Reporters was read, saying that it is the attitude of the Conference that the Reporter of each County Medical Society should be a member of the House of Delegates. The reasons and advantages for this proposal were given on a separate sheet.

Applications for active membership were received for Dr. Henry Ruffu, and Dr. Kenneth Henderson. These were referred to the Board of Censors.

Dr. E. H. Harvey proposed that the Society furnish speakers who will appear before various lay organizations in a campaign to educate the public in health matters. There was some discussion as to whether this included the question of medical economics. Dr. Allman said that the local society should await a concrete program which is now being evolved by the State Society. It was decided that those who were willing to coöperate with Dr. Harvey in public health education should communicate with him.

Drs. Sloane Stewart, Harry Hoffman, and Lewis Feinstein, were elected to membership.

There was a discussion regarding the unwritten rule that a candidate should have been in active practice in the county for a year before being eligible for membership. It was the concensus of opinion that a physician's ability to practice medicine and his general qualifications for membership were revealed by his year as interne in the Atlantic City Hospital even better than by a year spent in private practice.

Dr. Irvin, reporting for the Medical Advisory Committee, said that under a new set-up, the County E. R. A. is given a lump sum for all relief purposes. This sum is so far below the amount heretofore expended that it is urgently necessary to cut the costs of medical relief. He appealed to all members on the approved list to remember this fact when treating minor illnesses, and to make no more calls than are necessary for the minimum adequate attention.

Dr. Darnall, reporting for the Library Committee, announced that the Library has managed to keep going in spite of a diminished budget. Many valuable books have been added during the year.

As Chairman of the Public Health Committee, Dr. E. H. Harvey, presented a very complete report of the health activities of the various public and private health agencies of the County. He presented a plan for improvements in the Public Health Hour project in Atlantic County.

Dr. Irvin presented the Treasurer's report which disclosed a deficit. On his suggestion a motion was passed that the dues for 1935 be fixed at $18.00.

Dr. Allman, in presenting his report as President, spoke of our successful efforts to put the Physician's Lien Law in operation. He mentioned the excellence of the scientific programs we have presented this year. He announced the officers of the State Society are working on a definite program concerning the threatened socialization of medicine. He said that the E. R. A. was working as well as could be expected. He thanked the Ambassador Hotel for the excellent manner in which they have taken care of us, not only at our meetings, but also in supplying us with a large room to use as headquarters of the Society.

Dr. Conaway moved that Dr. Philip Marvel Sr., who has been an active member for over 50 years, be made an honorary member. The motion was carried.

The Secretary read amendments to the Constitution and By-Laws, the prinicipal one providing for both a secretary and a treasurer.

Dr. Shivers presented the following report of the Nominating Committee for the year 1935.

President: C. Coulter Charlton.

Vice-President: Samuel L. Salasin.

Secretary-Treasurer: John S. Irvin.

Treasurer (if the new by-laws are adopted): D. B. Allman.

Historian: H. L. Harley.

Reporter: Robert A. Kilduffe.

Delegates to the State Society
Term expires 1938

	Alternates
E. H. Harvey	W. A. Blampin
D. W. Scanlon	Robert Durham
D. B. Allman	T. H. Boysen

New Member of the Board of Censors
David B. Allman

Member of the State Nominating Committee
D. W. Scanlon

Delegates to Other County Societies

Clyde M. Fish	W. E. Darnall
Myrtile Frank	Cole Davis

These nominees were unanimously elected.

Dr. Allman then relinquished the chair to the new President, Dr. Charlton, who spoke a few words of appreciation and requested suggestions for the good of the Society.

The following scientific program was carried out:

"The Treatment of Backache from the Orthopedic Standpoint" by Drs. A. J. Davison and Morris T. Horwitz, Philadelphia; "The Painful Back" by Dr. A. M. Rachtman, Philadelphia.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on December 11, the President, Dr. A. Liva presiding. Approximately 55 members were present.

The minutes of the November meeting were read and approved, and the Executive Committee minutes as published in the Bulletin were approved.

The treasurer, Dr. Irwin, stated that the dues of 13 members remained unpaid for 1934, and that the dues for 1935 were coming in slowly. He said that it was very necessary for every member to pay as soon as possible.

The following communications were mentioned—by the secretary:

1. A letter from Dr. L. A. Wilkes stating that Senator Leap was available to represent the County Society at the presentation of the Physicians' Lien Law.

2. A letter from Dr. L. A. Wilkes announcing the "Plan for Medical Relief in Disaster", worked out jointly by the American Red Cross and the American Medical Association whereby the presidents of the State and County Medical Societies shall assume control and direct all melical relief in times of disaster.

3. A letter from Dr. Lancelot Ely, President of the Medical Society of New Jersey, announcing a joint meeting of the Board of Trustees, Dr. Weigel's Committee on the Physicians' Lien Law, and Senator S. Rusling Leap, to be held on Sunday, December 16, 1934, to consider the legal difficulties which have arisen in connection with the public hearings on the fee schedule demanded by the Physicians' Lien Law.

4. A letter from Dr. Frank W. Pinneo, Chairman of the Committee on Insurance of the Medical Society of New Jersey, in which he stated that the various types of insurance policies sponsored by the State Medical Society are applicable to all members, including junior and associate members.

5. A letter from the Treasury Department at Washington urging the secretary to take subscriptions to the Venereal Disease Information Journal which provides means of keeping abreast of all modern advances in Venereal Disease Work.

The following were elected to membership—

Regular:

Dr. G. T. Erickson, Hackensack.
Dr. L. R. Thompson, Wyckoff.

Junior:

Dr. D. C. Clarie, Closter.
Dr. Louis C. Cartnick, Woodbridge.

The following applications for membership were read—

Junior:

Dr. C. A. Abbate, Lodi.
Dr. W. G. Gardine, Bergenfield.
Dr. M. E. Branon, Rutherford.

Associate:

Dr. P. C. Colonna, Englewood.

In regard to the "Physicians' Lien Law", Dr. S. T. Snedecor moved that the Society endorse the action of the Executive Committee in engaging a local counsel to represent the Society when the Lien Law comes before the District Court. This motion passed after some discussion, in which Dr. J. Irwin stated that the Physicians' Lien Law had recently been contested in New Jersey. In these cases the Hospital Lien Law was also involved. Dr. C. de S. Pallen asked why the fee schedule had not been published and indicated that the insurance companies would fight the law if the present fee schedule were adopted.

Dr. Liva, President, appointed the following committees—

Budget Committee—Dr. J. H Irwin, Chairman, Dr. M. Sarla and the incoming Treasurer.

Committee on Collection Service Agencies—Dr. William F. Fitzhugh, chairman, Dr. H. B. Wilson and Dr. V. Farmer.

Committee on Incorporation of the Bergen County Medical Society as a Non-Profit Sharing Organization— Dr. S. T. Snedecor, chairman, Dr. W. M. Schmidt and Dr. S. T. Alexander.

The president read the report of the Nominating Committee as published in the Bulletin. Dr. F. S. Hallett moved that the nominations be closed. Dr. William L. Vroom seconded the motion and it passed unanimously.

Dr. R. H. Light, of Rutgers University, announced the Post-Graduate Course to be given this year.

Dr. Paul Klemperer, Pathologist of the Mt. Sinai Hospital, will give a series of six lectures on Monday evenings from 9 to 11.30, commencing January 14, 1935.

Dr. G. M. Levitas, Chairman of the Mutual Aid Committee, called for discussion of the proposed

Mutual Aid Association of the Bergen County Medical Society, which was read by our executive secretary. There was considerable discussion by many members as to whether the Mutual Aid Association should be compulsory or voluntary to the members of the Society. A motion by Dr. Levitas that we adopt the plan as submitted by the committee was passed 17 to 14.

An amendment by Dr. Witkoff that the dues be increased $2 and membership be compulsory was passed 22 to 18 after discussion. Since the vote was indecisive, Dr. Wilson, seconded by Dr. Levitas, that the concensus of opinion of those present was that the Bergen County Medical Society should establish a Mutual Benefit Association. This motion passed unanimously. The matter was referred back to the Executive Committee.

Mr. Harry Fleuchaus of the Way Agency, Inc., Newark, New Jersey, spoke upon the "Automobile Insurance" sponsored by the State Medical Society. He called attention to an editorial in the Journal of the Medical Society of New Jersey to the fact that the State Medical Plan of Automobile Insurance is saving each particular member much more that the annual dues in his County or State Societies. (See page 38.)

The meeting was then turned over to Dr. G. M. Levitas, Chairman of the Scientific Committee, who spoke on "Important Biological Factors in Fertility and Sterility" with a discussion of the so-called Safe Period which was demonstrated schematically by motion picture films.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held Tuesday, December 4, 1934, with F. William Shafer, M.D., presiding.

The program for the evening was as follows:

1. Symposium on Maternity Mortality:

History ..... Frank L. Kennedy, M.D. (by invitation)
Prenatal Management .... Frank F. Moore, M.D. (by invitation)
Delivery Management ..... Albert B. Davis, M.D.
Post-partum Management..Gordon F. West, M.D.

2. Livery Therapy in Anemia..H. I. Goldstein,M.D.

Application for membership of the following were voted upon: Dr. Elic Denbo, Dr. I. E. Ornaf both of Camden, Dr. E. Hemphill, Haddonfield and Dr. R. F. Roth of Westmont.

The special meeting held November 20, 1934, resulted in the following definite actions by the Society:

1. (a) Rejected the report of the Public Health Committee.

   (b) Approved in principle the Tuberculin testing in High School children in the County, but concluded that the matter be laid over for further observation and study.

2. Adoption of special introductory paragraphs and additions to the list of special fees to be placed in the Fee Schedule under the Physicians' Lien Law.

3. Renewal of the Agreement of this Society with the local E. R. A. for the ensuing year. Changes incorporated in the Agreement are as follows:

   (a) Obstetrical Fees to be raised from $15.00 to $25.00.

   (b) For Eye Refractions without mydriatics, $2.50; with mydriatics, $5.00.

   (c) Limit each physician to a maximum of $250.00 a month compensation for treating E. R. A. cases.

The local Emergency Relief Director has approved the agreement and changes recommended by this Society.

In order to provide medical care for the patients of the physician who has reached his $250.00 maximum for the month, the E. R. A. will provide the cost of medication if the physician will provide the medcal services. Medication is to be prescribed on regulation prescriptions with drugs of the U. S. P., or N. F. An agreement is being made with the druggists to fill these prescriptons.

The fee schedule as provided under the Physicians' Lien Law was presented before the Honorable Judge Neutze, November 23, 1934. A committee from the Camden County Bar Association appeared and requested postponement of the hearing. The Court set December 14, 1934, at 10 a. m., as the new date. This Society will be represented by Attorney S. Rusling Leap.

In order to test the reaction of the patient to medical care, as provided under E. R. A., a number of clients were interviewed on the following questions:

(213 cases interviewed)

1. Did you patronize Hospital Clinics before Emergency Relief Administration had medical service?

Hospital Clinics	79—37.1 per cent
Family Physician	121—56.8 per cent
Home Remedies	13— 6.1 per cent

2. Have you been satisfied with medical treatment as provided by Emergency Relief Administration?

Satisfied	213
Dissatisfied	0

3. Have you always been able to get the physician you requested?

Yes.....213 No.....0

4. What complaint, if any, do you make of medical service, or have you any suggestions?

1 complaint: too much red tape.

Comment: The last three questions show lack of freedom in criticism and should be disregarded.

To the physician doing E. R. A. work the following questions were submitted:

(20 physicians interviewed)

1. Do you find your hospital clinics have decreased in size during the year?

5 ..... Decreased
5 ..... No clinics
10 ..... Increased

2. Do you retain your own patients who have been forced to depend on E. R. A. for medical care?

20 ..... Yes

3. Have you had coöperation with E. R. A. officials in your district?

15 ..... Yes

Outside of city—fair but difficult. Overlapping districts increase red tape.

4. What is the most objectionable feature of the set-up?

(a) Red tape, dealing with papers and signatures required.
(b) Necessity of treating patients who use service because it is free.

Records of the two local hospitals having clinic service, show total number of patients treated in their clinics between January 1933, and October, 1933, to be 138,864. Between January 1934 and October 1934, 133,978. The total decrease was 4,886 out-patient treatments in the two hospitals.

The Public Health Hour, judging from the results obtained so far in the county, has not functioned as anticipated.

The secretary announces the death of Dr. J. Holbert Conoly, of Gloucester, on November 21, 1934, aged 46. (Journal, Dec. 1934, page 707.)

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

The annual meeting of the *Cape May County Medical Society* was held on Tuesday, November 13, 1934, in the Bellevue Hotel, Cape May Court House, having been deferred from the regular date of October 10th.

Arrangements were made for establishing and filing a fee schedule under the Physicians' Lien Law.

The following officers were elected:

President, Warren Robbins, of Cape May.

Vice-President, John B. Townsend, of Ocean City.

Secretary-Reporter, Eugene Way, of Sea Isle City.

Treasurer, H. H. Tomlin, of Wildwood.

Censor, Frank R. Hughes, of Cape May.

Nominating Committee to the State Society, Clarence Way, of Sea Isle City.

Public Health Committee, Aldrich Crowe, of Ocean City.

Welfare Committee, George F. Dandois, of Wildwood.

Alternate Delegate to the State Society, Oscar F. Ziegler, of Wildwood.

"Diabetes and Insulin" was the subject of a paper by Dr. A. Sindoni, of Landenau Hospital, Philadelphia, Pa.

Miss Ethel Hobson, Chief Dietician, described the diets used in the hospital.

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter.

President John F. Condon presided at the meeting of the *Essex County Medical Society* held at the Academy of Medicine, Newark, Thursday evening, December 13, 1934. The problems of the campaign for diphtheria immunization and vaccination were considered.

Dr. Charles V. Craster, Health Officer, reported his observation and the progress of the immunization work in Newark since April 1. 1934, when in accordance with the request of the Medical Society his department discontinued all free immunization. A survey showed 1430 immunizations in the past seven months as compared with 3,419 during the preceeding six months. Sufficient toxin-antitoxin and toxoid had been distributed to immunize 5,500 children but only 1,062 were reported so immunized. The recent child survey showed a total of 37,345 children under 6 years in Newark and of these 48 per cent were immunized against diphtheria, and 40 per cent vaccinated against smallpox.

Dr. Craster reported that diphtheria immunization was being continued in the Parochial Schools is-as-much as the City Public Schools were continuing it as before. However, before the child is immunized by the school doctor, the parents must sign a slip saying that they are unable to pay a private physician for this service.

Dr. George J. Holmes, Director of Health Education, Newark Public Schools, similarly reported that the policy of his department had been altered, the effort being mainly exerted to immunize those children whose parents are unable to pay for private medical attention. He also stated that many medical forms going to the parents of school children had been rewritten laying less stress on the service of free clinics and dispensaries, and encouraging rather the patronage of the private physician. He remarked significantly that the public has been educated for years to avail themselves of the free medical services and that, while it will take time, they can be educated to value the offices of the private physician.

Dr. Julius Levy, State Director of Child Hygiene, offered several valuable suggestions for the improvement of the immunization campaign. He said:

"A separate public health hour would encourage many mothers to go to the doctor who hesitate to go at the regular office hour. It would seem desirable to have as many doctors as possible select the same day for a public health hour, and even the same hour. While this might require some sacrifice or adjustment on the part of a number of physicians, it would have considerable educational publicity value. In order to overcome some natural difficulties in developing the transition from mass immunization to individual immunization, a great deal more general educational publicity is required. A publicity or educational drive in which would be enlisted churches, parent-teacher associations, newspapers, etc, should be developed. It is possible that some doctors do not fully understand the great value of the organized

profession of a successful immunization campaign. This was to be only the first step in reëducating many families to turn to the family doctor for certain kinds of preventive medical service."

Dr. Levy suggested that prepared printed advice, similar to the following, be handed by nurses to mothers in order to avoid misunderstanding.

"The Essex County Medical Society, recognizing the importance of having every child protected against diphtheria and smallpox, has obtained the names of physicians who are willing to do everything in their power to make this protection possible for every child. They have agreed to carry on this work in the following manner:

"1. To conduct a *Public Health Hour* in their own offices at which time they will immunize and vaccinate for $1.00 for each inoculation.

"2. To immunize and vaccinate in regular office hours for regular office fees.

"3. To give this treatment free of charge to those children whose parents in the judgment of the physician cannot afford to pay for it.

"Take your child to your family physician. You can learn from the nurse whether his name is on the list. If you find his name is not on the list, you should ask the nurse to give you the names of the physicians in your neighborhood who are on the list. The physicians through this plan have made it possible for every child to be immunized and vaccinated. Be sure to take your child at once to the doctor."

Mrs. H. Roy Van Ness, representing the Woman's Auxiliary with the campaign for immunization offering to coöperate and aid the doctors with ethical letters to patients, printed forms for nurses, reports to the health authorities, etc. She made the suggestion that physicians who are ready and willing to do the immunizing according to the plan display a special card which might indicate his health hour. Then patients could then be directed to the office where that card is displayed, eliminating the reference to a definite doctor.

Dr. Edgar A. Ill, urged coöperation with the immunization plan, the service being not only a duty, but good business. Fifty per cent of the immunizations have been paid for.

Dr. S. Rubinow made the valuable suggestion that physicians extend the service they offer at the health hour.

In the general business portion of the meeting other subjects were considered. Dr. E. Zeh Hawkes for the E. R. A. Medical Advisory Committee repeated the necessity for economy. Beginning the first of December funds for hospitals will be limited to pay for only the acutely sick, and acute medical and surgical emergencies. Members of hospital staffs should be careful to sign hospital claims for only emergency conditions.

Dr. William H. Areson, for the Welfare Committee, reported the organization of the Allied Medical Professions of the State, the Dentists, Pharmacists, Nurses, and Physicians, whose united efforts in a common cause should be most effective.

The public hearing to be held by the Court of Common Pleas, on the *Fee Schedule for the Physicians' Lien Laws* Tuesday, December 11, 1934, was adjourned four weeks until Tuesday, January 8, 1935.

Walter B. Mount and J. Irving Fort were elected Members of the Council at a meeting held Tuesday, November 13, 1934.

Committees have been announced for the 1934-1935 year. Two new committees have been created by President Condon. A Grievance Committee is provided to hear any complaint from anybody, while the Ethics Committee continues as before. The other new committee is to study the medical Practice Act, its membership being mostly composed of ex-officers.

The personnel of the committees is as follows:

ECONOMICS AND PUBLIC RELATIONS

A. Chas. Zehnder, General Chairman

SECTION ON ECONOMICS

James H. Lowrey, Chm.
H. C. Barkhorn
H. A. Brodkin
L. W. Brown
E. P. Cardwell
H. N. Comando
E. W. Erler
J. I. Fort
A. J. Ganley
A. S. Harden
P. H. Hosp
J. W. Hurff
S. Muta
J. N. Pannullo
A. Parasi
F. W. Pinneo
H. H. Satchwell
L. Schneider
E. S. Sherman
H. G. Vander Veer
H. R. Van Ness
W. H. A. Warner
F. C. Weber

HOSPITAL SECTION

E. W. Sprague, Chm.
F. A. Alling
A. W. Bingham
J. J. Connolly
M. Danzis
E. A. Flynn
J. F. Hagerty
F. R. Haussling
E. Holden
F. E. Hubbard
C. MacArthur
O. A. Mockridge
R. J. Mullin
C. R. O'Crowley
Guy Payne
E. P. Schaefer
B. J. Smith
G. W. Vannatta
E. H. Willan

PUBLIC HEALTH SECTION

Edgar A. Ill, Chm.
C. C. Beling
F. A. Bien
F. N. Carbone
R. N. Connolly
C. V. Craster
E. H. Crystell
G. J. Holmes
E. C. Klein, Jr.
J. Levy
G. A. McLellan
W. D. Minningham
J. D. Moore
A. Pilch
F. A. Pringle
B. B. Ranson, Jr.
E. L. Smith
E. H. Snavely
A. Stahl
E. B. Stokes
H. A. Tarbell
T. Teimer
G. B. Verbeck
W. W. Wolfe

MEDICAL PRACTICE ACT

Edward W. Sprague, Chm.
Wells P. Eagleton
Wm. H. Areson
H. H. Satchwell
C. C. Beling
John F. Condon
A. Chas. Zehnder
Edgar A. Ill
Frank W. Pinneo
F. R. Haussling

PHYSICIANS' LIEN LAW

J. Irving Fort, chm.
H. C. Barkhorn
C. F. Baker
C. C. Beling
H. N. Comando
A. C. Zehnder
H. H. Kessler
E. C. Klein, Jr.
B. B. Ranson, Jr.
F. D. Scudder
R. A. Schaaf

FINANCE

J. F. Condon, Chm.
F. W. Pinneo
R. H. Rogers
A. C. Zehnder

ETHICS

J. H. Lowrey
Wm. H. Areson
E. W. Sprague
J. F. Condon
A. C. Zehnder

NOMINATIONS

Wm. H. Areson, Chm.
W. D. Crecca
M. Greifinger
F. C. Weber
E. LeRoy Wood

CREDENTIALS

H. Roy Van Ness, Chm.
R. A. Schaaf
H. A. Schulte

TO STUDY CANCER
H. B. Orton, Chm.
A. R. Abel
Wm. H. Areson
C. F. Baker
L. W. Brown
Max Danzis
J. I. Echikson
Milton Friedman
John W. Gray
A. S. Harden
F. R. Haussling
Edgar A. Ill
H. S. Martland
W. D. Minningham
C. R. O'Crowley
G. P. Olcott
A. Yaguda

TO STUDY AND CORRELATE LUNG PROBLEMS
R. H. Dieffenbach, Chm.
I. Applebaum
F. P. Carrigan
E. I. Dorn
I. I. Miller
J. Polevski
Chas. Rich
H. H. Satchwell

TO STUDY AND CORRELATE HEART PROBLEMS
C. E. Teeter, Chm.
F. A. Alling
H. M. Ewing
L. Mancusi-Ungaro
E. V. Parsonnet
J. Polevski
H. H. Satchwell

TO STUDY ACUTE POLIOMYELITIS
R. N. Connolly, Chm.
L. W. Bagg
C. R. Brown
J. W. Gardam
F. W. Pinneo
E. W. Ripley
E. L. Smith

POST GRADUATE INSTRUCTION
H. H. Satchwell, Chm.
C. W. Barkhorn
J. I. Fort
B. A. Furman
Stuart Hawkes
E. C. Klein, Jr.
W. B. Mount

MEDICAL RELIEF ADVISORY
E. Z. Hawkes, Chm.
H. C. Barkhorn
Max Danzis
I. L. Farr
Edmund W. Ill
W. H. A. Warner

GRIEVANCES
H. N. Comando, Chm.
Anthony Ambrose
Maclyn Baker
D. M. Cerone
E. C. Klein
C. M. Tirrell

AUTOMOBILE EMBLEM
Alfred Stahl

MEMBERSHIP
Chas. F. Rathgeber, Chm.
Geo. Blackburne
W. D. Crecca
W. F. Grady
Edgar Holden
C. S. Janifer
L. G. Kirkman
L. Mancusi-Ungaro
H. A. Murray
C. M. Robbins
R. M. Rogers
J. W. Siegel
R. F. Tomec
F. E. Voorhees

PUBLICATION
J. H. Bradshaw, Chm.
Geo. Backburne
L. W. Brown
E. W. Erler
F. W. Pinneo
E. N. Riggins

MILK
E. G. Wherry, Chm.
A. R. Bianchi
R. N. Connolly
T. W. Harvey, Jr.
A. Heyman
Paul H. Hosp
Floy McEwen
H. A. Murray
R. H. Scott
Wm. H. Vail

ILLEGAL PRACTITIONERS
H. H. Satchwell, Chm.
R. N. Connolly
J. I. Fort
S. B. W. Leyenberger
J. S. Lincoln
E. Steiner

ENTERTAINMENT
R. J. Mullin, Chm.
G. A. Braun
J. I. Echikson
Wm. Grady
E. A. Seidman

RADIO BROADCASTING
Alfred Stahl, Chm.
D. A. Kraker
G. P. Olcott
E. LeRoy Wood

NECROLOGY
Floy McEwen, Chm.
H. A. Tarbell
E. G. Wherry

WOMEN'S AUXILIARY
F. J. McCauley, Chm.
Paul H. Hosp
Theo. Teimer
H. R. Van Ness

COMPENSATION BOARD
D. A. Kraker

WELFARE
Wm. H. Areson, Chm.
D. A. Kraker
J. B. Morrison
H. Roy Van Ness
E. LeRoy Wood

The following new members were elected at the Annual Meeting in October:

REGULAR

Alfred John D'Agostini, 41 Columbia Ave., Newark
Max Block, 48 No. Fullerton Avenue, Montclair
Leo E. Froomess, 775 High Street, Newark
John S. Kessell, 643 Central Avenue, East Orange
Herman Moschkowitz, 739 High Street, Newark
Mary Dunning Rose, 453 Park Avenue, Orange
Augustus S. Stanfield, 94 Oakwood Avenue, Orange

ASSOCIATE

Enrico H. Albano, 242 Clifton Avenue, Newark
James O. Clayton, 516 Broad Street, Newark
John J. Flanagan, 15 Fulton Street, Newark
Samuel Geller, 784 High Street, Newark
William Henry Di Giacomo, 2 Prospect Pl., Newark
Leonard Sidney Greenfield, 691 Clinton Ave., Newark
Paul W. Haley, 229 Smith Street, Newark
Eugene M. Katzin, 50 Baldwin Avenue, Newark
Dominic Macaluso, 531 Joralemon Street, Belleville
Charles S. Morrow, 321 South 9th Street, Newark
Eugene F. Mullin, 515 Sanford Avenue, Newark
Guy Payne, Jr., 9 South Prospect Street, Verona
Robert F. Rapp, 13 Burroughs Way, Maplewood
Arthur E. Sherman, 25 Prospect Street, E. Orange

The following new members were elected at the December Meeting.

REGULAR

Elizabeth F. Bigelow, 117 Irvington Avenue, S. Or.
Joseph Bove, 306 Lincoln Avenue, Orange
Anna R. Schults, 207 Summer Avenue, Newark
Aldona Slupas, 369 Belmont Avenue, Newark
E. M. Aikman, 30 Oak Lane, Essex Fells
Irving P. Borsher, 255 Broad Street, Bloomfield
Wilfred Carrol, 56 Goodwin Avenue, Newark
Baxter Lee Clement, 31 Clinton Street, Newark
Robert E. Jennings, 143 Park Street, East Orange
Charles Kimmel, 10 Johnson Avenue, Bloomfield
Wolf Lurie, 398 Avon Avenue, Newark
Ralph A. Pattyson, 144 Harrison Street, E. Orange
Alexander Robbins, 24 Johnson Avenue, Newark
Earl W. Roles, 25 N. Harrison Street, East Orange
Joseph G. Tirico, 791 Bloomfield Avenue, Montclair
Raymond E. Wolf, 47 Lawrence Avenue, W. Orange
Saul Zager, 471 Hawthorne Avenue, Newark
Edmund A. Zybulewski, 410 Bergen Street, Newark

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* meeting on December 20 at the Hotel Pitman, Pitman, was addressed by Dr. Max Strumia, Associate Pathologist of the University Hospital, on "Bacteriophage, Bacteriolysis and Their Therapeutic Applications".

The resignation of Dr. Henry L. Sinexon, of Paulsboro, as Vice-President of the society was accepted and Dr. M. F. Lummis, of Pitman, was elected to fill the vacancy.

Interesting reports were presented by Dr. Sinexon, Chairman of the Physicians' E. R. A. Committee, and Dr. I. W. Knight, Chairman of the Public Health Committee.

It was announced that Dr. C. D. Pedrich, of Glassboro, is sick and unable to attend to his practice.

At the close of the meeting the members of the Woman's Auxiliary joined the doctors for a buffet supper.

Members present were: Drs. H. L. Sinexon, Paulsboro; C. I. Ulmer, Gibbstown; B. A. Livengood, Swedesboro; Duncan Campbell, E. E. Downs,

Dorothy Rogers, H. B. Diverty, W. E. Crain and Fuller G. Sherman, of Woodbury; I. W. Knight, W. J. Burkett, H. B. Chalfant, V. I. Barrows and M. F. Lummis, Pitman; William Pedrick, Glassboro; Don Weems, Wenonah; T. M. Gairdner, Gibbstown; and R. K. Hollinshed, Westville.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* convened in annual session at the Trenton Country Club on December 12th, 1934.

President Connelly appointed an Auditing Committee after Treasurer North had presented his annual report. The committee reported later that the books and accounts of the Treasurer were found to be regular in every respect.

Dr. Sommer, reporting for the Fee Schedule Committee, stated that its activities were suspended pending a conference of state officials concerning this subject.

Dr. Haggerty gave a condensed resumé of recent legislation, which was both interesting and instructive.

Dr. R. H. C. Phillips, reporting for the Health Committee, made a stirring appeal for a more earnest coöperation with respect to the "Public Health Hour".

Dr. Wilbur Watts made a very entertaining report on the work of the E. R. A., and stated that the committee had accepted the present plan for continuation another year.

Following discussion on the subject of the functions of the Advissry Committee to the E. R. A., the motion was carried that the society go on record as in favor of the appointment of a member of the society to this committee.

President Connelly in expressing tribute to the members of the society who have died during the past year, announced that a few minutes should be devoted to a memorial service and called upon several members to give expression to the memory of the deceased.

The following applications were read and referred to the Membership Committee: Drs. H. L. Drezner, F. M. Hammell, Robert Forer, Elizabeth L. Martin, P. B. Reisinger, S. E. Watov, and M. R. Zentner.

The following applicants were duly elected:

Drs. T. E. Camper, S. G. Fine, A. E. Franzoni, Alexander Klein, Paul Klempner, Edward Kuch, C. B. Matthews, S. R. Miller, S. E. Seidelman, F. S. Storaci, H. W. Swertfeger, E. L. Waldron, A. A. Wilner and W. F. J. Wittenborn were elected associate members.

Drs. J. J. Belfer, N. H. D'Gianni, J. B. Spradley, J. A. Tempesto, H. S. Urbaniak and LeRoy A. Wilkes were elected active members.

Several important communications were read and commented upon with action by society motion.

The motion carried that the Reporters of Component Societies should be elected Delegates to the State Society.

During the discussion of certain phases of the E. R. A., Dr. Wilkes clarified many of the confusing problems that have arisen, accompanying the progress of this feature of relief in general.

The following Officers, Delegates and committee appointments were regularly elected and announced:

President, Dr. R. J. Cottone.

Vice-President, Dr. R. G. Stone.

Secretary-Reporter, Dr. A. D. Hutchinson.

Treasurer, Dr. H. R. North.

Dr. C. H. Mitchell was reëlected a member of the Board of Censors. Dr. H. R. North was reëlected a member of the Nominating Committee, with Dr. D. L. Haggerty as Alternate. Drs. D. B. Ackley, H. D. Bellis, R. B. Seely and Nathan Swern, whose terms of office as Delegates expired, were reëlected. Drs. Samuel Blaugrund, R. J. Cottone, W. E. D'Arcy and B. D. Lavine were reëlected Alternate Delegates.

President Cottone appointed Drs. J. F. Pessel, E. B. Beairsto and A. J. Fessler as the Program Committee.

The President also reappointed Drs. Bellis, Adams and Sista as the Membership Committee.

Through the death of Dr. J. O. McDonald, a vacancy was sustained on the Legislative Committee and Dr. J. A. Connelly was appointed by the President for this position.

The President expressed an earnest desire that the invitation from the Woman's Auxiliary for members of the society to take an active interest in procuring speakers to address several civic organizations on health subjects be cordially accepted; and appealed for coöperation from the members in this direction. The President stated that Mrs. J. J. Belfer will receive such notifications.

The following amendment to the By-Laws was submitted by the Secretary, and ordered to first reading:

"Associate Members shall have all the requirements and eligibility required for Active Membership.

"They shall have all the rights and privileges of Active Members, except the right to vote and hold office and to acquire (active) membership in the Medical Society of the State of New Jersey.

"Associate Membership shall be limited to *one* year, and the Secretary shall notify all Associate Members upon the termination of their associate membership, of their eligibility to apply for Active membership, and that failure to thus apply within a period of *six months* terminates his or her membership in the society.

"Application for membership in the society at any time following the termination of a one-year associate membership shall be for Active membership only.

"Any former member of the society desiring to be reinstated, shall apply for active membership, and be reinstated only by a two-thirds vote of the members present at a regular meeting, and upon such conditions as the society may prescribe.

"All previous motions relative to Associate Membership heretofore recorded are hereby abrogated."

Following discussion, the Finance Committee, composed of Drs. G. W. Williams, F. G. Scammell and A. D. Hutchinson, were appointed a committee on the bond of the Treasurer.

MIDDLESEX COUNTY

G. F. Hilker, M.D., Reporter

The annual meeting and banquet of the *Middlesex County Medical Society* was held at the Hotel Woodrow Wilson in New Brunswick on December 19th, 1934. In the absence of President Joseph Mark, the Secretary, Dr. Edward F. Klein, presided.

The following were admitted as Associate Members:

Dr. J. H. Degenhart, New Brunswick.
Dr. Eugene A. Hauber, Sayreville.
Dr. J. S. Uhr, New Brunswick.
Dr. P. Downing, Jamesburg.
Dr. H. B. Copelman, New Brunswick.
Dr. Lawrence H. Lief, Jamesburg.

The Advisory Board's report for the year was given by Dr. G. W. Fithian, in which the appointment of a certain number of relief doctors on a yearly salary was opposed, it being the idea of the Board that medical advisers to the relief organization would be a better solution to the problem. It was estimated that relief moneys obtained by Middlesex phyysicians for the past year would total $50,000.

The Treasurer, Dr. Marshall Smith, reported on the society's financial status. The report was approved.

Dr. Mann, reporting for the Public Health Committee, stated that Middlesex County had done very well in the Diphtheria Immunization Campaign despite the lack of sufficient funds being appropriated by local municipalities. During the coming year greater stress will be placed on immunizing the school-age child through coöperation with the County Superintendent of Schools.

The Public Health Committee was also active in advising the profession of legislation of interest to them. It was urged that we adopt a militant attitude in respect to the legislators, and show that we are a united and powerful body.

Dr. McKinstry urged more doctors to appear at Trenton during legislative sessions so that we may become better acquainted with what is happening there.

A report by Dr. K. Rothschild, Director of the Mental Hygiene Division, was read, in which it was shown that the number of inmate days in the County Workhouse had been reduced by 8000. Also, the intelligence in this group was below normal in 60 per cent of the cases. It appeared that work in crime prevention is to be done in our public schools. Due to the work of the Mental Hygiene Division, twenty cases were kept out of the institution and returned to the care of the family physician. The effort of the division has been to integrate the whole field of mental hygiene, sociology and crime prevention.

The Nominating Committee's Chairman, Dr. R. L. McKiernan, gave their recommendations, which were unanimously passed. The following were elected for the year 1935:

President, Dr. Harry Haywood, New Brunswick.
Vice-President, Dr. J. J. Mann, Perth Amboy.
Secretary, Dr. F. X. Taber, New Brunswick.
Treasurer, Dr. A. M. Smith, New Brunswick.
Reporter, Dr. G. F. Hilker, Perth Amboy.

Delegates for three-year term expiring 1937:
Dr. Wm. C. Wilentz, Perth Amboy
Dr. R. L. McKiernan, New Brunswick
Dr. F. C. Henry, Jr., Perth Amboy.

Delegates for one year:
Dr. W. E. Sherman, New Brunswick
Dr. J. F. McGovern, New Brunswick
Dr. J. V. Smith, Perth Amboy
Dr. B. F. Slobodien. Perth Amboy
Dr. J. Mark, Woodbridge.

Alternate Delegates:
Dr. P. Avery, New Brunswick
Dr. R. Faulkingham, New Brunswick
Dr. G. W. Fithian, Perth Amboy
Dr. F. L. Brown, New Brunswick
Dr. W. London, Perth Amboy
Dr. L. Wetterberg, Woodbridge
Dr. C. Morris, Metuchen
Dr. E. Kleiber. New Brunswick.

Members of State Nominating Committee—one year:
Dr. R. L. McKiernan, New Brunswick
Dr. F. L. Brown (Alternate), New Brunswick.

The newly elected President, Dr. Harry Haywood, then took the chair. He offered a glowing tribute to the excellent and conscientious work of the retiring Secretary, Dr. Edward F. Klein, for the past two years. The President pledged himself to promote the business of the society, and asked for full coöperation from the members of the society.

The speaker of the evening, Lieutenant Sullivan of the U. S. Narcotic Division, gave a talk on his experiences both in the Narcotic Division and in the Naval Intelligence Department. He also urged the doctors to follow minutely the rulings for the handling of narcotics by doctors, stressing especially the fact that all doctors must purchase their $1.00 opium and narcotic stamp yearly. He asked that all doctors make themselves familiar with exceptions one and two of Article 85 of the laws dealing with narcotics.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The November meeting of the *Monmouth County Medical Society* was held in the Auditorium of the Jersey Central Power and Light Company, Allenhurst, N. J., on Wednesday, November 28, 1934. The following executive committee report was read:

"A meeting of the Executive Committee was held at the Monmouth Memorial Hospital, Long Branch, on Monday, November 12, 1934, at 8.30 p. m. The following men were present: Doctors Rullman, Watkins, Blaisdell, Parry, Altschul, Herrman, Nichols, and Featherston.

"Communications were read and ordered filed."

It was announced that a public hearing on the Fee Schedule in connection with the Physicians' Lien Law will be held in the Court of Common Pleas, Freehold, on November 27, 1934, at 2.00 p. m. It was decided to have Attorney Theodore Parsons at the hearing to give us legal advice if necessary. The Secretary was instructed to send an

announcement of the hearing to the State Executive Secretary, Dr. LeRoy Wilkes, and Senator Rusling Leap, Legal representative for the New Jersey State Medical Society.

The request of the Dental Society to hold joint meetings with the Medical Society to discuss mutual economic subjects was deferred until after January 1st.

The Monmouth County Organization for Social Service sent us a report of the Health Committee as of September 24. In this report it is stated that difficulties have been experienced all over the county in reference to volunteers for transporting indigents to hospital clinics. It was the opinion of our committee that the volunteers and nurses could take the patients to a doctor's office in the immediate vicinity at a much lower cost. The secretary was instructed to notify the Monmouth County Organization for Social Service of our views in this matter.

The matter of group hospital costs was referred to the Economic Committee with the request for a detailed report at the next meeting. It is reported that the State Executive Secretary is attempting to have the dates of the annual meeting of the county societies changed so that they will all take place at approximately the same time. It is felt that this would greatly simplify the work of the State Society, and that the records would be accurate and up-to-date.

After a prolonged discussion as to the method of electing our county officers and the selection of the Executive Committee, it is believed that a change in the procedure would be of benefit to our Society. As a result of these discussions, the following changes in the By-Laws are recommended and will be voted upon at the annual meeting in December:

1. Chapter 2, Meetings, Sec. 1, to read as follows:

"Regular meetings shall be held at 8.30 p. m. on the fourth Wednesday of each month, excepting July and August. The meeting in April shall be considered the annual meeting and shall mark the end of the fiscal year. Election of Officers for the ensuing year shall take place at this meeting."

2. Chapter 4, Committees, Sec. 6. to read as follows:

(a) The Nominating Committee shall consist of the five (5) preceding past presidents. This Committee shall choose one nominee for each office to be filled at the annual meeting."

"(b) Nothing in this section shall be construed as preventing any member from making additional nominations at the annual meeting."

3. Chapter 3, Duties of Officers, Sec. 9, to read as follows:

"The Executive Committee shall consist ex-officio of the President, Vice-President, Secretary-Treasurer, retiring President, and in addition nine (9) members elected at the annual meeting, the first year for terms of one, two, and three years, and each succeeding year for three years. It shall be the policy of the Society to have the officers picked from men who have been members of this committee for at least three years."

"(c) Seven (7) members shall constitute a quorum."

The above recommendations will serve as a written notification as required by the Constitution and By-Laws."

A discussion of the changes in the By-Laws followed.

A letter from the Secretaries and Reporters Conference in which it was advised that reporters be made delegates to the State Meeting was read.

The following physicians were admitted to the Society:

Dr. Sabastian P. Vaccaro
Dr. Victor Knapp
Dr. Stephen Sewell
Dr. Joseph E. Bossone
Dr. Howard C. Pieper

The following scientific program was presented:

1. "Fetal Mortality in Breech Delivery", by Dr. Frank J. Goff, Red Bank, New Jersey;

2. "Fibroids in Pregnancy", by Dr. William E. Studdiford, New York City.

These papers are submitted for publication in the Journal.

The December monthly meeting of the *Monmouth County Medical Society* was held at the American House, Freehold, New Jersey, on December 12th, 1934. The suggested changes in the By-Laws which had been discussed at the November meeting were adopted. The Treasurer's report was given and the Auditing Committee reported the books to be correct. A balance of $141.00 was reported.

A motion was made that we demand medical representation on the State Emergency Relief Administration for this locality.

The following officers were elected for the coming year:

President, Dr. Warren H. Fairbanks, Freehold, N. J.

President-Elect, Dr. Walter A. Rullman, Red Bank, N. J.

Secretary and Treasurer, Dr. Daniel A. Featherston, Asbury Park, N. J.

Reporter, Dr. James P. Pregnall, Asbury Park, N. J.

The Board of Censors includes:
Dr. Harvey S. Brown, Freehold, N. J.
Dr. L. F. Albright, Spring Lake, N. J.
Dr. Kenneth Brown, Asbury Park, N. J.
Dr. R. B. Wilson, Red Bank, N. J.
Dr. Murray Woronoff, Keyport, N. J.

Drs. C. Byron Blaisdell, Long Branch, and Frank Altschul, Long Branch. were named delegates to the State Convention to be held in Atlantic City in June.

New members of the Executive Committee are:
Dr. Walter W. Gosling, Red Bank, N. J.
Dr. O. K. Parry, Asbury Park, N. J.
Dr. B. Blaisdell, Long Branch, N. J.
Dr. F. Altschul, Long Branch, N. J.
Dr. O. R. Holters, Asbury Park, N. J.

The Program Committee includes:
Dr. Robert A. MacKenzie, Asbury Park, N. J.
Dr. Victor Knapp, Asbury Park, N. J.
Dr. R. W. Baeseman, Asbury Park, N. J.
Dr. John C. Clayton, Freehold, N. J.
Dr. W. G. Herrman, Asbury Park, N. J.
Dr. Berkeley Gordon, Marlboro, N. J.
Dr. B. Blaisdell, Long Branch, N. J.
Dr. O. K. Parry, Long Branch, N. J.

MORRIS COUNTY

Dr. Marcus A. Curry, Reporter

A regular quarterly meeting of the *Morris County Medical Society* was held the evening of December 20 at the State Hospital at Greystone Park.

President McMahon presided over an attendance of about fifty members and guests; included in the latter were Executive Secretary LeRoy A. Wilkes, and Editor of the State Journal, Frank Overton, M.D.

Routine business included the reading by Secretary Ward of minutes of preceding meetings and of the Executive Committee.

Dr. Albert W. VanSickle, of Chester, New Jersey, was unanimously elected to membership.

Treasurer Young made a very lucid financial report indicating the necessity for an increase of the annual dues so that the society should have sufficient funds for its need in carrying on its work as indicated by the officers of the State Society and the various committees who are so ardently working for the betterment of the medical men.

Action was unanimously taken to discontinue the society library that for several years had been maintained at the Morristown Library, the use of which by the members not justifying the annual outlay for this purpose.

Action was also unanimously taken to increase the annual dues of the members from $15 to $20.

The program of the meeting was on the activities of the Morris County Medical Society.

Dr. Elvira Dean Abell, Chairman, Public Relations Committee, spoke on "Why the Public Health Hour Is of Vital Importance". The discussion was led by Dr. Krauss and Dr. Sherman.

Dr. Byron G. Sherman, Chairman, E. R. A. Committee, described the "Results of the Work of the E. R. A. in Morris County and New Developments in Its Function". Several members of the society entered into the discussion.

Dr. Inglis F. Frost, Chairman, Physicians' Lien Committee, spoke on the subject "The Developments in the Physicians' Lien Law Work in Morris County with Instructions as to the Procedure in the Individual Case". This address was discussed by members of the society.

Dr. Abell recommended a form of an "ethical letter" to be sent by the family doctor to parents as a means of promoting interest in and an understanding of the "Public Health Hour". This project was adopted (page 6).

The speaker and the various members entering into discussion stressed the importance of making a success of this hour by contacting and interesting various groups such as the Parent-Teacher Association, nursing groups, and the use of local newspapers, as well as aggressiveness on the part of the individual physician in systematically keeping after the heads of families of his clientele. The line of demarcation between the "Public Health Hour" and private practice was clearly defined. All the speakers emphasized the importance of winning back all this work to the office of the physician if they are to regain and maintain control of these medical activities, as against having them go under other control.

Dr. Sherman gave freely of his intimate understanding of the functions of the E.R.A. medical work. He defined shifts of policy and elucidated the type of patient eligible, and drew the line of distinction between chronic and acutely ill and emergency patients; and told how the different types of patients should be handled.

Dr. Frost detailed the progress and status of the lien law work, stating that the schedule of the Morris County Society was filed on December 18, and notice of this was published, although on January 18 there will be a hearing before Morris County Common Pleas Judge Holland. Dr. Frost also explained the grounds of the impending attack made on the constitutionality of the act, and said that his committee expects to meet with the Bar Association and insurance physicians to try to straighten the matter out before it goes to the Supreme Court.

The discussion of the subjects presented was actively taken up by the members, and the participations of Executive Secretary LeRoy A. Wilkes, M.D., and Editor Frank Overton, M.D., were distinct contributions which were very manifestly appreciated.

President McMahon submitted a proposal for a modification of the Constitution and By-Laws so that regular meetings could be held more frequently than quarterly, and in this way various propositions depending upon the action of the members at a regular meeting could be handled with greater speed and facility. Formal notice of the proposed changes was given.

After a session that was as interesting as it was lengthy, the meeting adjourned to enjoy refreshments in the hospital cafeteria.

OCEAN COUNTY

Abraham Goldstein, M.D., Reporter

The annual meeting of the *Ocean County Medical Society* was held November 14, 1934, at 6.30 p. m. at the Elks Clubrooms in Lakewood, N. J. A delightful dinner was served, after which the business of the evening was transacted, with the President, Dr. Abraham Goldstein, presiding.

The minutes of the previous meeting were read and approved, followed by the reading of communications and reports of committees.

The Committee for Arrangements of the meeting of the Fourth Councilors' District reported that the Laurel-in-the-Pines Hotel, Lakewood, would be the best place to have this meeting. A motion was therefor passed to that effect.

The Committee on Publicity reported that it would be advisable to have an educational article printed each month in one of the county papers

showing the progress of medicine during the past fifty years. It was approved by the body with the understanding that all articles will be read at the Medical Society meeting first, and if approved will then be printed in the paper, signed by the Ocean County Medical Society.

Dr. A. Goldstein, Chairman, appointed the following committee to be present at the hearing on the Physicians' Lien Law at Toms River, N. J., on December 7, 1934: Drs. Disbrow, Towbin, Hayden, Herbener, Goldstein, Halbach. A request was also made that all members, if possible, be present.

The following officers were elected for the ensuing year:

President, Dr. Alfred Woodhouse, Toms River, N. J.

Vice-President, Dr. Robert Buerman, Lakewood, N. J.

Secretary, Dr. W. G. Hayden, Toms River, N. J.

Treasurer, Dr. Frank Bower, Toms River, N. J.

Reporter, Dr. Abraham Goldstein, Lakewood, N. J.

Delegate—Nominating—Three-year term, Dr. E. Herbener, Lakewood, N. J.

Dr. Hendrickson was elected a member of the society at this meeting.

The Treasurer's report was read, following which a motion was made that the dues for the coming year be $13.00.

The meeting was well attended and, as Commander Rosendahl of the U. S. Navy was being honored with a reception at the Elks Club that evening, a motion was made and carried that the meeting be adjourned and we all join in the celebration to honor Commander Rosendahl.

PASSAIC COUNTY

S. W. Johnsen, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Board of Health, Paterson, Thursday, December 13th, at 9 p. m., Dr. H. F. Willard, President, presiding.

The following candidates were elected to membership:

To Regular Membership

Dr. J. Reuben Budd
Dr. Charles S. Labash

To Associate Membership

Dr. Julian Cohen
Dr. Fred James Crescente
Dr. Paul B. Ferrary
Dr. Joseph A. Maffongelli
Dr. William Bruggy Ruocco
Dr. Frederick Isadore Schwartzberg
Dr. James S. Stokes
Dr. Andrew Bogert Vanderbeek, Jr.

Dr. Willard then announced that the speaker of the evening, Dr. Stephen Perhan Jewett, Attending Psychiatrist, Flower Hospital, New York City, was unable to attend because of illness in his family, and Dr. Rothman would read Dr. Jewett's paper.

The title of Dr. Jewett's paper was "Psychiatry and Modern Medicine". Dr. Rothman elaborated on the paper and an exeellent discussion resulted.

Drs. Markel, Drake and Wassing discussed the paper.

Dr. Willard was nominated and unanimously elected as our member of the State Nominating Committee. Dr. Joseph was elected as Alternate.

Dr. Willard was then nominated and unanimously elected as the new member of the Board of Censors.

The Committee for the revision of the By-Laws was then announced by the Chairman, namely: Dr. Murn, Dr. Mitchell, Dr. Hall.

Dr. MacMillan then reported that the progress of the Diphtheria Immunization Campaign was far from satisfactory. This resulted in a discussion as to where the fault lay. Various members expressed the idea that the children were not coming to the physicians. Dr. McBride then made a motion, which was duly seconded and carried, to the effect that the Boards of Health and the E. R. A. be notified that the physicians of the Passaic County Medical Society were ready and doing all in their power to immunize all children, but that there were very few children presented for immunization.

On motion of Dr. McBride, a rising vote of thanks was given to the retiring President, Dr. Willard, for the marked efficiency with which he had performed the duties of the office.

Dr. MacMillan, the incoming president, then was presented, and he also commended the retiring president, and expressed the hope that the same spirit of coöperation would continue to make his term of office a continuation of the good work.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular meeting of the *Salem County Medical Society* was held at the Salem County Memorial Hospital December 12, 1934, with an attendance of fourteen members and guests, Dr. F. L. Perry presiding. In the course of the regular business meeting Dr. William H. James tendered his resignation as Reporter and Dr. Lee C. Hummel was elected to fill the vacancy.

Dr. Knight of the State Board of Health put forth a plea for the members of the society to use more of the smallpox vaccine and diphtheria toxoid furnished by the state for the immunization of children. After a very free discussion by most of the members present, the consensus of opinion seemed to be that the plan for the family physician for taking over the work of the school physician of immunizing school children had so far been a failure. This, it seems, had been due mostly, in our county at least, to the fact that *the public had not been sufficiently sold on the idea.* Therefore, a motion was passed instructing the committee on public health to put on a more extensive and instructive advertising program in order to obtain the interest and coöperation of the parents of the school and pre-school child. Practically all the physicians of the county are signed up to give their time for this work, but are having difficulty in getting parents to bring their children in for vaccination and diphtheria immunization.

The scentific session consisted of two closely correlated papers by Drs. T. B. Lee and A. H. Lippincott, of Camden, N. J. Dr. Lee spoke on "Sterility in the Female"; and Dr. Lippincott ably con-

cluded the subject by speaking on "Sterility in the Male". Dr. Lippincott particularly stressed the importance of psychic factors as a cause of impotence in the male. All seemed encouraged by his talk.

After the meeting, we retired to the hospital dining room where general discussions took place over sandwiches and coffee.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

A largely attended regular meeting of the *Union County Medical Society* was held at Overlook Hospital, Summit, on the evening of December 12th. Dr. Edward S. Krans, President, was in the chair. Much routine business was transacted before the speakers of the evening were presented. They were Dr. Anthony Bassler, New York City, who spoke on "Colitis from the Practitioner's Standpoint", and Dr. Raymond J. Connors, also of New York, whose topic was "Office Treatment of Common Rectal Conditions". Their interesting presentations were much enjoyed and followed by a general discussion.

The following were elected to membership:

Dr. Rudolf J. Baruch, 414 Elizabeth Ave., Elizabeth
Edw. G. Bourns, 126 Harrison St., Westfield
Arthur L. Chapman, 11 Hazelwood Ave., Rahway
Wm. M. Golden, 70 Irving St., Rahway
Edw. J. Gonozy, 25 Elm St., Elizabeth
Percy L. Hipple, Jr., 226 Walnut St., Roselle
Wm. H. Kelley, 129 Summit Ave., Summit
Andrew L. Laurie, 664 Newark Ave., Elizabeth
Gregory E. Sacco, 567 Colonial Ave., Westfield.
David Spivack, 944 E. Jersey St., Elizabeth
Chas. A. Squires, 602 Central, Plainfield
Martha W. Tyndall, 519 E. Broad St., Westfield
Alice E. Tyndall, 519 E. Broad St., Westfield
Harry J. White, Bonnie Burn San., Scotch Plains
Philip L. Wolgin, 445 Elmora Ave., Elizabeth
Robert O. Yuckman, 224 W. Jersey St., Elizabeth
Stephen Dow Milis, 132 S. Euclid Ave., Westfield
Jessie D. Read, 618 Elm St., Westfield

At a late hour refreshments were served, and a social interval followed.

OBITUARIES

DR. JOSEPH BINDER

Joseph Binder, M.D., F.A.C.S., of 422 Bergen Avenue, Jersey City, N. J., died at 8:15 p. m. November 17, 1934, of apparently a coronary thrombosis. He was 44 years of age and had received his medical degree from the New York University in 1915.

Dr. Binder served during the World War as an officer in the American Expeditionary Forces of the U. S. Army. He was attending obstetrician and Chief of the Second Division at the Margaret Hague Maternity Hospital, Jersey City; and also was visiting obstetrician to Greenville, Fairmount, and Christ Hospitals, Jersey City, N. J.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING NOVEMBER, 1934

Supplied by the State Department of Health

Name	Place of Death	Residence	Date of Death
Joseph Binder	Jersey City	Same	November 17, 1934
Edgar Carroll	South Brunswick	Dayton	November 18, 1934
James H. Conoly	Gloucester City	Same	November 21, 1934
William M. Goodwin	Newark	Same	November 21, 1934
John J. Lynn	Teaneck	Ridgefield	November 13, 1934
Samuel A. McBride	Long Branch	Neptune	November 3, 1934
Watson Rodemann	Newark	Same	November 16, 1934
Geoffrey Tunison	Oxford	Same	November 4, 1934
Edward P. Uptegrove	Sussex	Same	November 22, 1934

THE WOMAN'S AUXILIARY

AN EDITORIAL BY THE STATE PRESIDENT

A definite project conducted by the Auxiliary as a part of a similar project by the Medical Society was proposed and urged by the new administration in a comment on page 496 of the Journal of August, 1934. The same issue of The Journal carried a leading editorial urging that the Woman's Auxiliary concentrate its major efforts on a publicity project in which the Auxiliary should be a liaison group to bring the county society into close relation with the lay health organizations, particularly in supplying medical speakers on popular health subjects. This plan was approved by The Medical Society of New Jersey, and Dr. Ely appointed an advisory committee to the Auxiliary, consisting of Dr. Dan S. Renner, Skillman; Dr. Edward W. Sprague, Newark; and Dr. W. K. Campbell, Long Branch.

The plan was adopted by the Executive Committee of the Woman's Auxiliary in Camden on October 8, 1934, as reported in the Journal of October, page 612.

We suggest that each County Auxiliary set the project in operation, securing a request from some lay group—a Parent-Teachers' Association—that the county medical society assign one of its number as a speaker on a specific subject at a definite time. When the project is once started, it will gain power and momentum, and will become an established feature of both the Medical Society and the Auxiliary.

Mrs. A. J. Casselman,
President.

Atlantic County

Reported by Mrs. James H. Mason

A meeting of the Executive Board to the *Woma'ns Auxiliary to the Atlantic County Medical Society* with seven members present was held on Friday, November 30, 1934. Mrs. Casselman's letter of explanation on the Speaker's Bureau was read. Two names were suggested as new members. Mrs. David B. Allman reported that all plans for the benefit card party to be held on December 3, 1934, were completed.

A regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on December 14, 1934, at the Ambassador Hotel. A communication from the Pleasantville branch of the American Red Cross and Visiting Nurses' Association was read, in which the Auxiliary was thanked for its donation. Mrs. Casselman's letter on the Speakers' Bureau was read. Mrs. North stated that a copy of the letter had been given to the Advisory Board of the County Medical Society, who promised to bring it before the County Society to ask for volunteers and their subjects so that a complete list will be ready for our next meeting.

The Program Chairman, Mrs. Salasin, suggested that Dr. Clara K. Bartlett be asked to give a book review.

The Widows and Orphans Chairman, Mrs. Harvey, reported one possible application.

Christmas donations were given to Pine Rest County Tuberculosis Hospital, Atlantic City Municipal Hospital, Atlantic City Day Nursery, Atlantic City Red Cross, Atlantic City Welfare Fund, and Betty Bacharach Home from the proceeds of the benefit card party given on December third.

The Membership Chairman, Mrs. Stewart, reported that she had written to all eligible doctors' wives who were not members. Mrs. Nickman was welcomed as a new member. Two other prospective members were introduced. Eighteen were present.

Burlington County

Reported by Mrs. M. M. Schisler

The *Woman's Auxiliary to the Burlington County Medical Society* held a Fall luncheon at the Willows, Mount Holly, on September 19, 1934, at 1 p. m. The President, Mrs. G. E. McDonnel, presided.

The Secretary and Treasurer presented their reports, which were accepted and approved.

The guest speaker was Miss Augustiva Atkinson, Superintendent of Nurses of the Burlington County Hospital. After a business meeting the members enjoyed a visit to the Burlington County Hospital.

On Wednesday, November 14, 1934, at 2 o'clock a tea was held at the home of Mrs. Lyman B. Hollingshead at Pemberton. The guest speaker at this meeting was Mrs. Arthur J. Casselman, State President. Mrs. Casselman talked on the history of the Medical Auxiliary.

A scholarship of $500 established this year will be offered by the Auxiliary of the Burlington County Medical Society. This scholarship will be offered each succeeding year by the Auxiliary on the basis of scholarship and worthiness.

The next meeting will be on Wednesday, March 13, 1935, with an inspection of the county institutions, almshouse, Fairview Sanitarium, and Hospital for Insane at New Lisbon. The Auxiliary will be entertained by Mr. and Mrs. McIllvain, Superintendent.

Monmouth County

Reported by Mrs. W. W. Gosling

Following its regular business meeting presided over by the President, Mrs. William K. Campbell,

of Long Branch, the *Woman's Auxiliary to the Monmouth County Medical Society* heard an interesting and vivid description of China, its people and their customs. The quarterly meeting was held at the Garfield-Grant Hotel, and was preceded by luncheon in the solarium.

The speaker of the afternoon was Miss Margaret Gorey, of Monmouth Memorial Hospital, who told of her four years' experience in China. The vastness of the country, the climate, language, and the money were discussed generally and then Miss Gorey limited her subject to Peking and presented a colorful picture of the personal lives of the Chinese in that city, their customs and everyday habits.

The next meeting will be in March, the date and place to be announced according to arrangements which will be made by Mrs. William Hermann. The Secretary's report was given by Mrs. Otto R. Holters and the Treasurer's statement by Mrs. Murray Woronoff. Announcements were made of the meeting of the American Medical Society in Atlantic City June 10-14, and the State Society's meeting on April 30, May 1 and 2. Miss Dorothy Reynolds was appointed Public Relations Chairman.

Somerset County

Reported by Mrs. Charles F. Halsted

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the Nurses' Home of Somerset Hospital, Thursday, December 13th, at 8:30 p. m. Mrs. Lancelot Ely, the President, presided. Nine members were present: Mesdames Ely, Flint, Reuver, Adams, Sperra, Hageman, East, Halsted and Baker.

The minutes of the previous meeting, also the Treasurer's report were read and approved.

The Hygeia Chairman, Mrs. Sperra, reported very satisfactory results from her work.

We had the honor of having with us our State President, Mrs. A. J. Casselman, who gave us a brief history of the Auxiliary from the time of its formation in Dallas, Texas, in 1918. She said that the organization in some localities was of a social nature, and she was very desirous that the women of the individual societies speak on health problems before our civic organizations and local clubs. The Speakers' Bureau could also be consulted. She asked that our organization stand for our husbands, our homes, our country, and our community.

Mrs. Remble F. Hegeman, Program Chairman, gave a very interesting book review on "Immigrant Gifts to American Life" by Allan H. Eaton. It was most instructive and revealed how much we are indebted to our neighbors, especially in the world of art.

After a pleasant discussion the meeting adjourned, and refreshments were served.

The Auxiliary is looking forward to a musicale some time in April; and also to card parties in the near future.

Union County

Reported by Mrs. Frederick A. Kinch, Chairman Publicity Committee

The *Woman's Auxiliary to the Union County Medical Society* held a reciprocity meeting at the home of Mrs. P. duBois Bunting, 712 North Broad Street, Elizabeth, on Monday afternoon, November 26th. Members of Parent-Teachers' Associations and Women's Clubs of Union County were guests of the Auxiliary. Over seventy members and guests were present.

The following is taken from an account of the meeting as reported by the Elizabeth Daily Journal:

"Speakers were Dr. LeRoy A. Wilkes, Executive Secretary of the New Jersey State Medical Society, and Mrs. H. V. Hubbard, of Plainfield, Chairman of Public Relations of the County Medical Society's Auxiliary and membership head of the State Auxiliary.

"Dr. Wilkes spoke of the changes pending in the medical profession. He compared the older type of physician, who gave much of his time and services free, with the younger physician who holds that the State should finance medical attention extended to those unable to pay personally. The newer school, however, is opposed to the socialization of medicine, Dr. Wilkes declared.

"He urged that various groups decide on action to be taken on whatever health problems they encounter in their work, and to present them to the medical profession. By keeping direct contact between physicians and social, educational and club workers, many health problems can receive closer supervision and given better solutions.

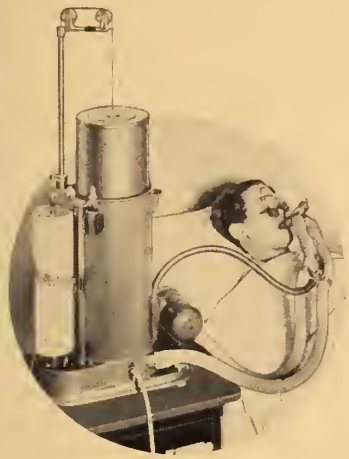
"Mrs. Hubbard said the Auxiliary aims to aid physicians in creating points of contact with the public by establishing speakers' bureaus. A list of topics and health questions will be available, and medical men will be prepared to present those topics to various groups. Another point of contact, she stated, is through the magazine 'Hygeia,' which is written for the public and deals with many angles of medicine. Mrs. Hubbard distributed copies of the magazine.

"Mrs. H. H. Bowles, of Summit, presided, and with Mrs. George Orton, of Rahway, poured at tea, which followed the meeting. Members of the Executive Board of the Auxiliary who served as hostesses were Mrs. Bunting, Mrs. Frederick Kinch and Mrs. George Laird, of Westfield; Mrs. Charles H. Schlichter, Mrs. Alden R. Hoover and Mrs. George Seymour, of Elizabeth; and Mrs. Orton, Mrs Bowles and Mrs. Hubbard."

The regular meeting of the *Woman's Auxiliary to the Union County Medical Society* met at the home of the President, Mrs. H H. Bowles, in Summit, Wednesday evening, December 12th. The business meeting was followed by a talk by Dr. Barney, returned medical missionary from Arabia. She gave many interesting details of the habits of the natives, their mode of life, sanitary conditions (rather unsanitary), and the difficulties experienced in establishing a hospital and getting the people to go to it.

A social hour was enjoyed after the address. Several members were added to the roll of membership, and all in attendance voted a very enjoyable evening.

The next meeting will be held in February.



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MEDICAL EXECUTIVE OFFICER

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ANNUAL MEETING, ATLANTIC CITY, APRIL 30, MAY 1 and 2

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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CONSTANCY

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You couldn't have done more if he had been your own child. We've always known this, and yet your bill has lain here, put off month after month, while bills for other things have been paid.

It wasn't that we didn't want to pay you, for we did. But after we bought those things necessary to keep us going—food, and clothing, and coal—our bank balance was pitiful to behold.

Now, thank heavens, things are a little brighter. And here at last is our chance to send you something more than thanks for all you did for Bobby and for us.

Sincerely,

Mrs. J____ B____

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DETROIT, MICHIGAN
The World's Largest Makers of Pharmaceutical and Biological Products

Volume XXXII.
Number 2

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Under the
Direction of the
Committee on Publication

Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

The Medical Society of New Jersey at Work

The Medical Society of New Jersey enrolls over 60 per cent of the physicians of the State as members. Excluding the considerable number of physicians who have retired from practice and those who have been in practice too short a time to come into full membership, over 80 per cent of the practicing physicians are active members of The Medical Society of New Jersey. The Society, therefore, truly represents the Medical Profession of the State.

A reliable index of the efficiency of a Medical Society is the proportion of its members who serve as officers and committeemen and carry on its activities. Judged by this standard, *The Medical Society of New Jersey* is very much alive and active.

STATE SOCIETY OFFICERS

The list of officers and committeemen which is printed in each issue of The Journal on advertising pages xx and xxi contains 215 names. Deducting 40 duplications of those who occupy two or more positions, 175 individuals are now serving as officers and committeemen. This is nearly six per cent of the members of the State Society, indicating that about one in every sixteen of its members occupies an official position in the Society.

COUNTY SOCIETY OFFICERS

The plan of organization of the State Society is duplicated in each of its twenty-one component or County Societies. The officers and committeemen of the local societies carry out the details of the State Society activities in their own counties.

The officers and committeemen of the County Societies number over 900 individual physicians, or 30 per cent of their total membership. This is about the proportion in the two largest counties, Essex and Hudson.

The smallest county societies have a larger proportion of members serving as officers and committeemen, Salem and Cape May each enrolling 80 per cent of its membership in official service. This large proportion of responsible workers in the small societies is necessary in order to carry on the diversified activities which are fostered by the State Society.

These statistics of active workers justify the title of this editorial, *The Medical Society of New Jersey at Work.*

Definiteness of Objectives of Medical Societies

A medical society is efficient in proportion to the definiteness of its objectives, and the directness of its efforts to attain them.

The business of a successful medical society does not run itself; it is the result of careful planning by a few leaders, and of purposeful effort by the members.

A physician in private practice is successful in proportion to his ability to secure the hearty coöperation of his patients and their families and neighbors.

A medical society is efficient to the extent that it adopts and promotes definite projects in which the individual members can take part.

MEDICAL LEADERS

All great movements for the benefit of mankind are developed by individual leaders. The *medical leader* is the physician who has outstanding knowledge of the trends of thought and purpose of the people, and can develop projects which the community is willing to adopt.

Leaders in private practice are those physicians who understand not only the scientific principles of medicine, but also the psychology and the peculiarities of the patient and all the members of his family.

The best leader in a medical society is the successful practitioner who can impart his knowledge and inspiration for service to his colleagues and to the people. He is able to distinguish that which is visionary from the matter-of-fact, and the idealistic from the practical. A physician is a potential leader if he can analyze a problem into its simple elements, and can indicate the points of agreement and disagreement among disputants.

A medical society problem is half settled when it is clearly stated, even as the question of treating a private patient is half solved when a correct diagnosis is made. The society is efficient when its leaders develop plans and projects which their colleagues can understand and will carry out, and which the community will understand and approve.

The honor of leadership in a medical society is imposed upon its officers and committeemen who are assigned to the duty of making practical plans for the members to execute. The officer is successful to the degree that he inspires and directs others to carry on the work which he initiates. When the efficient leader relinquishes his office and returns to the status of a private in the ranks of the members, he will still retain his influence as the mentor of his successor and his associates.

Holding office in a county society is both an *education* and an *opportunity*. It dispels some illusions and cherished beliefs, but it reveals and clarifies projects which the members are ready to support.

EVIDENCES OF LEADERSHIP

A medical society does not run itself. Its efficiency in getting things done comes from thoughtful planning not only definite objectives, but also the means and methods of attaining them.

The Camden County Medical Society, the seventh in size in the state, has adopted five major objectives, which it announces in its Monthly Bulletin of January, 1935, as follows:

1. To attain a 99 per cent membership of the physicians of the county in this Society.
2. Revision of Constitution and By-Laws.
3. A more active interest in our County Society work by committee chairmen and members.
4. Establishment of the office of Medical Examiner for this county. This would replace the present archaic coroners' system.
5. Continued interest in the economic phase of the physician's life.

The Essex County Medical Society, the largest in the State, with over 800 members, has its work well planned under twenty-five committees whose personnel and scope are set forth in the January issue of this Journal, page 49.

Definite activities and programs are announced in the Monthly Bulletin of the Hudson County Medical Society, the second largest society in the state, having 391 members listed in the last official roster. But the smaller societies also promote definite projects, some of them having over eighty per cent of their membership serving on active committees.

STANDARDS OF EFFICIENCY

It would be difficult to apply standards for measuring the efficiency of all county medical societies, for they are voluntary associations working under conditions which are far from uniform. However, three tests of efficiency are available.

1. The regular meetings of a society indicate whether or not the officers are promoting definite projects and have a clear schedule for the meeting. The manner in which officers conduct a meeting is very suggestive of the manner in which they conduct the other affairs of the society.

2. The reports of the society activities which are sent to The Journal show that the officers of the societies are making progress in the adoption of definite projects and activities. The index of the activities of the societies in the 1934 Journal affords tangible evidence of a growing appreciation of the importance of these efforts.

3. The officers of the State Societies are in a position to judge the efficiency of local programs and projects. They are always ready to advise and encourage the local officers in developing and carrying out their programs and projects.

Supervision of Tuberculosis Cases

Tuberculosis is usually a *social* disease in the sense that the effective treatment of most patients requires the participation of social and welfare agencies as well as the individual patient and his family physician. The disease is usually insidious in its onset, and chronic in its course, reducing or destroying the earning power of the patient and yet imposing an expense for treatment. Nearly every patient is confronted with a serious economic problem which requires the attention of welfare agencies.

The patient's family must also be considered. The wife or husband, and the children are exposed to infection and are often poorly nourished and clothed because of the reduced finances of the family. The services of the nursing and welfare agencies are therefore as essential as those of the family physician.

Sanatorium care of the patient is often necessary for three reasons:

1. The removal of the source of infection from within the family.
2. Medical treatment in all its phases.
3. The instruction of the patient regarding his mode of life and methods of protecting others from infection.

SYSTEM OF SUPERVISION

Nearly every community has a system of care and protection consisting of three elements:

1. The family physician.
2. The public health nurse.
3. The sanatorium and advisory clinics.

The system works with a considerable degree of satisfaction and efficiency in the detection, diagnosis, and hospitalization of cases. In fact, the criticism is sometimes made that the system may be over-worked, as for example, in subjecting *all* school children to diagnostic tests.

Defects in the administration of the system are most apparent in the follow-up of positive cases after their discharge from the sanatorium, when supervision and advice are needed over weeks and months. More particularly, a large percentage of the misunderstandings concern the use of the records of the cases after the patients have returned home from the sanatorium.

The General Medical Law and the code of ethics of the medical profession forbid the physician from disclosing his knowledge of any facts gained during his professional relations with the patient. But the Public Health Law requires the doctor to disregard this general principle and report all cases of certain communicable diseases to the local health officer and the State Department of Health. The law, court decisions, and public sentiment, all unite to justify placarding the home of a patient who has an acute contagious disease, the justification for the publicity of the placarding being the protection of other people.

On the other hand, the welfare of the tuber-

culous patient himself is the justification for the use of the clinical records of his case by his family physician, and the public health nurse, and possibly the welfare official, while all other persons are denied access to the records.

USE OF CASE RECORDS

A standard method of procedure is that, when a patient is discharged from a sanatorium, his clinical record shall be sent to his family physician. The family physician shall then give to the public health nurse such information as she may need in order to instruct the patient and make progress reports to be added to the sanatorium records.

To carry out this procedure requires the cooperation of four groups of persons:

1. The family physician.
2. The sanatorium officials.
3. The public health nurse and the organization for which she works.
4. The patient, his family, and his friends.

The relations of these groups frequently give rise to many questions:

Does the patient have a family doctor? and will he coöperate with his medical advisor?

Under whose auspices does the nurse work? Are her employers in the good graces of the physicians and the sanatorium officials?

Is the public health nurse tactful in her dealings with the doctor and the patient?

When a misunderstanding occurs, on whom is the responsibility?

These are examples of questions which are frequently arising in dealing with patients discharged from sanatoriums. They cannot be answered collectively; each question requires an individual reply. Who shall supply the answer?

The *Public Health Committee* of the county medical society is the usual body that considers all phases of tuberculosis management. When the committee is active, it can devise satisfactory answers to practically all disputed points of the relations of hospital superintendents, physicians, nurses, and patients.

Freedom of the Press and of Medical Service

Governmental regulation of the publishing business has striking resemblances to the official control of the practice of medicine in compulsory health insurance and free medical service to those who are economically unfortunate. The subject was discussed in a meeting of the National Association of Book Publishers on January 16, when Walter Lippmann spoke for the *freedom of the press* in arguments which would apply also to the principle of *freedom of medical services.*

Extracts from Mr. Lippmann's address, which was printed in the New York Herald Tribune of January 17, will indicate the similarity of his point of view to that of the leaders in the medical profession.

Referring to the N. R. A. Code, Mr. Lippmann said:

"Publishing should never have been put under N. R. A. Codes, and publishers should never have accepted them voluntarily."

"What are codes? They are specific regulations applying to different sorts of publications. When publishers and editors, and writers accept the principle that a government authority may make specific laws for books, magazines, and newspapers, they have accepted an evil precedent which threatens the freedom of the press. They have admitted that the government may regulate the economic basis of the press; and if a government can regulate the economic basis of the press, it can regulate what is printed by the press.

"The freedom of the press is much too important a thing to be dealt with on the notion that intelligent and well-intentioned men happen at this moment to be in power in Washington. It has to be guarded, as the most sacred part of our heritage and the foundation of all our other liberties, on the presumption that some time or other, in the midst of a crisis we cannot now forsee, attempts will be made to destroy the freedom of the press. The liberties of man are not yet so secure that they do not have to be defended with the utmost vigilance. And I say that if ever the attempt

is made to destroy the freedom of the press, these codes will furnish the means to do it and the precedent by which it can be done.

"You may say these things won't happen. It is enough for me that they could happen. If some one stood up in Washington and said, 'Let us have a press censor; he will be very liberal' * * * would you agree to that? You would not. Well, I say you should not have agreed to let the government impose codes regulating the business of publishing no matter how confident you felt that the codes would not now interfere with the freedom of the press. A good censor is still bad because you know that he might easily be followed by a bad censor. By the same token a good code is bad because it might easily become a bad code.

"Surely, the only position for publishers, editors and writers to take is that they are subject to the general laws of the land, within the guaranties of the Constitution, and that for the rest they will accept no favors from the government. They will recognize no authority in the government to regulate them specifically.

"And that, therefore, when the N. I. R. A. expires in June, they will ask for no code and accept none. They are removing the Blue Eagle from their publications because the right to publish in America is guaranteed by the Constitution, and no license, no decoration, no official stamp of any kind is necessary, is desirable, is consistent with the American tradition of the freedom of the press."

Substitute "Freedom of Medical Service" for "Freedom of the Press", and Mr. Lippmann's arguments will apply to the present agitation for a change in the system of the practice of medicine.

Organized Medical Participation in Health Projects

Physicians have always been willing and active in coöperating individually in sound health projects in their community where the aims were clearly stated and approved and the results expected justified the continuation of the project. Their services have been given freely in projects organized and controlled by agencies other than the Medical Society. The cooperating physician has rarely been looked upon as a delegated representative of the County Medical Society; but he has been regarded rather as an interested member of the Lay Organization for whom he provides medical service.

Too often the statement has been made that "the medical profession does not coöperate in Community Health Programs". While this is untrue, there is some ground for the belief, since usually the Medical Society has not been officially asked to approve or provide this service.

Until the individual physician participating in health projects in his community does so only in response to a formal request made in a recognized manner to his County Medical Society, the criticism of the attitude of the medical group as a professional society will continue. After the Medical Society has investigated and approved a project and defined the scope of the professional contribution of physicians, certain of its members will serve on a committee as the designated representatives of the medical profession in respect to the project. Such formal action will demonstrate that the medical profession is not antagonistic to worthy health projects, but will support them when physicians are approached through their medical society.

A formal invitation to the Medical Society for the members to participate in the early conferences, and to develop plans for the conduct of the health services, will provide the recognition and appreciation of the services to be rendered by the medical profession; and such an approach will engender a coöperative spirit and secure the support and participation of the profession as represented in the Medical Society.

The individual physician, when approached with a request to partcipate in an activity, should demand that this request for his services be made through the Medical Society; and he should state that only with the approval

of his society will he take part in the proposed activity.

Conditions today demand organized effort, and the medical profession must provide this in order to gain due recognition for the extensive contributions of its members as individuals. In union there is strength—and recognition.

LeRoy A. Wilkes, M.D.,
Executive Secretary.

County Maternal Welfare Commissions

The Essex County Medical Society initiated maternal work in New Jersey in March, 1923, by forming a Commission for Maternal Welfare. The good results of the work of the Commission led the House of Delegates of The Medical Society of New Jersey in 1931 to authorize the establishment of a Committee on Maternal Welfare whose duties should be threefold:

1. To organize a Maternal Welfare Commission in counties under the auspices of the County Society.

2. To coördinate the efforts and achievements of the Commissions.

3. To prepare an annual report to the State Society and to make recommendations for conducting the work. (Transactions, 1931, page 42.)

Dr. A. W. Bingham, East Orange, who had been active on the Essex County Commission, was made chairman of the new committee and has held the position ever since. The committee has organized a commission in every county and has held semi-annual conferences with their members, one being during the Annual Meeting of the State Society.

The annual report of the State Committee in 1934 contained two recommendations (Journal, May, page 292):

1. Greater coöperation among physicians doing obstetrics.

2. More consultations in difficult labors.

The Reference Committee of the House of Delegates added the following recommendations (Transactions, 1934, page 38):

1. To list maternal deaths more accurately.

2. To promote prenatal care in rural communities and in thickly congested districts.

3. The State Committee to prepare press releases to be used by local newspapers throughout the state.

It is unfortunate that The Journal has not received more notices of the activities of the County Commissions. Each Commission is a committee of its county society and an integral part of The Medical Society of New Jersey. It should make reports to its county society as regularly as the other committees. The pages of The Journal are always open for the reports.

The Journal has printed four original articles on Maternal Welfare during the past year as follows:

The Avoidable Factors in Maternal Mortality—By Dr. P. F. Williams, Philadelphia, Pa., January, 1934, page 11.

Prenatal Care and Its Relation to Maternal and Infant Mortality—By Dr. R. L. DeNormandie, Boston, Mass., October, 1934, page 570.

Prenatal Care—By Dr. A. W. Bingham, East Orange, November, 1934, page 619.

The Reduction of Maternal Mortality in New Jersey—By Dr. W. B. Mount, Montclair, this issue, page 65.

The Committee on Maternal Welfare has adapted a set of rules for the management of obstetric cases in hospitals, which appears on page 100 of this Journal.

The scientific presentation of the methods and objectives of maternal welfare has been done well and fully; and the organization of the County Commissions has been accomplished. The next step must be to popularize the movement among practicing physicians, and publicize it among the people.

ORIGINAL ARTICLES

THE REDUCTION OF MATERNAL MORTALITY IN NEW JERSEY

By Walter B. Mount, A.B., M.D., F.A.C.S., Montclair, N. J.

Read at a Meeting of the New Jersey Hospital Association at Atlantic City, N. J., June 8, 1934

During the past six months maternal mortality has received its full share of publicity through the printed and the spoken word. Doctors especially interested in obstetrics have heard many, and some prolonged, discussions of this question. But why this increased interest in a subject that at all times should and does hold the logical and humanitarian interest of all of us?

Late in November, 1933, the Commonwealth Fund of New York City published the book "Maternal Mortality in New York City. A Study of All Puerperal Deaths 1930-1932".[1] The Committee on Public Health Relations of the New York Academy of Medicine was responsible for the work, at the instigation of and with an initial loan of money by the New York Obstetrical Society. The Commonwealth Fund assumed the considerable expense involved. Similar work has been carried out in Boston, in Philadelphia,[2] in Essex County, New Jersey,[3] and elsewhere, and the results of some studies have been published. A notable contribution is the English book by J. M. Munro Kerr, "Maternal Mortality and Morbidity".[4] The New York report[1] represents an excellent bit of arduous work. Then on November 20th, 1933, the Medical Information Bureau of the New York Academy of Medicine released to the daily newspapers an abstract of the book under the title "Why Women Die in Childbirth". Although very properly presenting many of the outstanding facts, the newspaper articles placed the emphasis wrongly. The conclusions of the book and the newspaper reports showed evidence of incomplete scrutiny and not altogether thoughtful and fair interpretation of the statistics. Discussion was rife by all concerned. Since then the writer has attended at least five meetings where this book and the news articles formed the basis of formal and earnest discussion. In April a seven-page pamphlet[5] was published by the New York Obstetrical Society as a report of its committee to review the book. This is not the time or place to attempt to summarize all these opinions.

One of the premises in the book[1] is unfair—the comparison of maternal mortality with the decreasing incidence and fatality rates from communicable diseases through prophylaxis. Birth control, of course, would diminish the total and percentage of maternal mortality.

Maternal mortality in New Jersey has decreased only slightly in the last six years. Some counties and some cities show better results than the average. How can we who are interested in hospital management aid in the improvement which must continue more rapidly in the future?

Better prenatal care is very important. This has improved so that in one city over a term of years the ward obstetrical patients showed a higher and higher number who had been to the clinics—an increase from 10 to 64 per cent.[3] We must get women to come to these clinics early in pregnancy, and to report faithfully. Here the visiting nurses can be of considerable help by looking up and getting to the clinic delinquent patients and also new patients. Post cards are less valuable than personal visits by the nurse. Under certain conditions the nurses may take blood pressures and examine urines at the patients' homes, and transcribe their findings on the clinic records. The nurses hear about one patient from another. Proper publicity can help much. Our work in Essex County received a whole page in a Sunday newspaper this spring. Women's Clubs and Junior League organizations may help. Interesting talks to mothers on preparation for pregnancy, supplies, etc., will attract women to hospital clinics. In the New York report,[1] in 36.7 per cent of the preventable deaths the patient was held responsible. She

failed to meet the requirements for proper care in one of two ways.

"1. Those cases where the patient failed to obtain medical advice, in which group we include the cases in which either from ignorance or neglect the patient failed to obtain proper care during the prenatal period or to call an attendant at the onset of labor or the development of strikingly abnormal symptoms.

"2. Those cases in which the patient failed to coöperate with her attendant by neglecting or refusing to follow his advice for the proper regime during pregnancy, the treatment of abnormalities, or the management of delivery or the puerperium, such as neglect of diet or bed rest in the treatment of toxemia, refusal to go to the hospital when so advised and lack of coöperation in getting a sufficiently long period of rest in the puerperal period.

"It must be borne in mind that in many, if not most, instances where the patient has been held responsible, we recognize that she is, in fact, helpless by reason of circumstances which are not of her making and lie outside of her control. She may be, and very often is, the victim of poverty or ignorance and, in such eventualities, it is manifestly the failure of society to provide proper and effective education, assistance, and care, which have forced her, unwittingly and surely unwillingly, to become the deciding factor in her own death. Clearly, it is only those patients who have willfully failed to obtain care and follow the advice given by their attendants, who can justly be held responsible for the outcome." [1]

On June 6th Dr. De Normandie of Boston read a paper before the State Society Meeting here on prenatal care in relation to maternal and infant mortality.[6]

Dr. Joseph B. De Lee of Chicago for years has claimed that as a protection against infection the obstretrical patients should be housed in a physically separate building and not in a general hospital.[7] Medical and surgical cases may bring in organisms with them. But this ideal is seldom possible. In New Jersey there are only five hospitals with separate maternity buildings, the Englewood Hospital, the Margaret Hague Maternity Hospital in Jersey City, the Newark Memorial Hospital, the Orange Memorial Hospital and the Mercer Hospital in Trenton. In New York State there are only a few such buildings. Increased hospitalization of patients in the last decades is a fact and we feel should help, especially in prolonged and difficult labors. A home delivery as a one-man job is satisfactory only in a short and normal labor. But we must have facilities to protect these patients by segregating them from all other patients. There must be separate delivery rooms (not to be used as operating rooms) and labor rooms, and enough of both to avoid crowding. There must be rooms available for immediate isolation of suspicious or frank cases of infection, fever, or other dangerous conditions in mother or baby. In one of our hospitals new patients are all detained in small admitting wards until they have had negative throat cultures. Isolation of the patient in labor from family and friends lessens the chances of infection. Ward patients should not remain in the ward during labor. This necessitates a sufficient number of labor rooms and the personnel to care for them.

Overcrowding of the obstetrical department should be avoided. An 85 per cent occupancy is considered the highest for good results, said a well-known Professor of Obstetrics and Gynecology. On the day in question his department was 89 per cent full, which increased the chances for infection. There should be opportunity to clean and air rooms and small wards. These facts are not appreciated by lay boards of trustees, who are anxious to keep every private or pay bed filled all of the time.

Visitors in any hospital are perhaps a necessary evil. From the standpoint of lessening possibilities of infection we could wish there were no such people. We can limit their numbers, arbitrarily in the case of ward patients. We can forbid children below a certain age to enter as visitors. Some boards of health have such rules. For maternity patients, especially private patients, we can truly say that for the first week there should be no visitors except members of the immediate family; other visitors tire our patients out too much and often are really unwelcome.

Deliveries by internes and residents must

be properly supervised, in even normal cases at the start of their work, and in abnormal cases at all times. We must see that our obstetrical staff members do not become lax in this regard. It is best to have the staff member scrub up with the interne so as to actually assist him. Also, internes must be supervised in their conduct of labors so that the proper time for interference may not be lost forever.

Operative deliveries of any sort, including cesarean sections, must be done only for suitable indications; and should be performed by those sufficiently skillful. The control of the courtesy staff members is important and needs great tact and at times firmness. They manage this best in the Elizabeth General Hospital in Union County, where all general and special surgeons are graded according to their abilities. One group is given full privileges in a certain kind of operations; a second group can do all but certain (few) major operations; and a third group does minor operations only. Otherwise they must be assisted when operating. Similar rules apply in their delivery rooms. Ask Mr. Mays about this feature, which is stated to be satisfactory and seems worth copying. Consultations should be sufficiently frequent, and early enough in the individual case. Even attending obstetricians themselves need supervision and control and have been known to do foolish things.

Cesarean section has shown a high mortality rate, especially when done for improper indications or at the wrong time. Consultation before a cesarean should be obligatory in all cases. Too many cesareans are being done in certain sections and some of them by men whose qualifications are scant for this work. Also the general surgeon is too prone to do this particular operation. He probably can do a very good operation, but the necessity for the operation should be passed on by someone with obstetrical experience. Cesareans on eclamptic patients are especially bad. The low type of operation undoubtedly is a safer procedure from the standpoint of infection, especially if the patient has been in labor or the membranes have been ruptured. The Latzko is a real extraperitoneal operation but is technically difficult and for a few years still it may be too much to ask that some one man in each hospital be qualified to perform it. It does allow of operation in a frankly infected case. In cesareans as in all operations we must be sure of the quality of our catgut.

We must stress the importance of consultation where necessary or desirable; and do away with any stigma attaching to the physician asking for consultation, so that he will request consultations early enough and cheerfully. The consultant should be tactful. The fee for the consultant might be waived, if necessary, or kept at a figure suited to the patient's status. All attendings see many ward cases without any fee. Last winter our Essex County Maternal Welfare Commission urged upon the Council of the County Society that they recommend compulsory consultation or supervision by an accredited obstetrician in all operative or prolonged labors. By accredited obstetricians we meant men serving on obstetrical departments of hospitals. Later the County Society passed the following:

"This Commission has conducted a six years survey of the obstetrical work and statistics in sixteen hospitals in Essex County. In these hospitals as a group during these years it was found that ten per cent of maternal deaths followed cesarean sections and that a large percentage of the other maternal deaths occurred after other obstetrical operations.

"In conformity with the ideals of the American College of Surgeons, it is strongly recommended that in every major operative obstetrical procedure and in every abnormal or prolonged labor supervision or consultation must be had; that this may be given by any qualified consultant. It is assumed that this matter will be handled with the utmost tact and consideration for the patient concerned, for her family and for her physician. It is further taken for granted that the question of any fee for consultation be entirely a secondary matter and be waived absolutely whenever desirable, as has been done heretofore in many cases."

You see, we were and are attempting to get the backing of others than obstetricians in support of the idea that obstetrical consultations are a good thing, and necessary to lower ma-

ternal morbidity and mortality. As hospital directors and superintendents, you might bring the weight of your position to bear in furthering this truth.

The following include most of the major obstetrical procedures referred to in the Manual of Hospital Standardization of the American College of Surgeons:

Abdominal hysterectomy for therapeutic abortion
Cesarean section—abdominal and vaginal
Craniotomy
Embryotomy
Forceps—high and mid
Induction of labor (?)
Version and extraction.

Two hospitals require consultation with one of the obstetrical staff in the following cases:

Breech presentation
Cesarean section
Difficult forceps delivery
Eclampsia
Occiput posterior position requiring instrumental correction
Placenta previa
Prolonged labor (24 hours)
Toxemia of pregnancy
Version
Other abnormalities and complications.

You could help by reporting to your County Commissions for Maternal Welfare any puerperal deaths occurring in your hospitals, and by aiding the Commissions in investigating the deaths by interviewing doctors, internes and nurses and looking over charts. The health officers are asked to do this reporting, so that deaths of patients delivered and dying at home will also be reported.

The abortion problem is large and difficult of solution—a social as well as a medical problem. A whole evening in May was devoted to this topic by the New York County Medical Society. Perhaps hospitals can help by insisting on consultation before the performance of therapeutic abortion, and by insisting on isolation of septic abortions or abortions of any type and insisting on the conservative treatment in the presence of fever or infection. In fact, no abortion really should be placed in a ward with pregnant or puerperal women.

The midwife problem hardly concerns you directly. The midwives in the middle Eastern states are caring for fewer patients year by year. They have been a menace in abnormal cases at any rate. The preventable mortality for the midwives in New York was 75 per cent of the 8.5 per cent cases delivered by them, although only 2.2 per cent of the total mortality.[1] Two of our hospitals are giving formal courses for midwives already licensed.

You can urge the members of your obstetrical departments to visit other hospitals and clinics, attend obstetrical meetings, and even take post-graduate courses in Philadelphia, New York or New Haven.

Masks over mouth and nose should be worn at all times in the delivery room during labor, and by all present when the vulva are exposed. One soon becomes used to the mask. But an excellent article by Blatt and Dale[8] in Surgery, Gynecology and Obstetrics for September, 1933, shows that gauze masks, even of several thicknesses, act only as filters. Muslin masks we tried; they are more efficient filters and not uncomfortable. Masks of impervious materials are much better, and cellophane seems the practical material at present. The cellophane mask of these authors[8] and Dr. Harley's cellophane mask[9] we have tried. The cost of this mask, $140.00 per 1000, seems prohibitive in these times. But they can be made by the nursing staff.

Other points stressed by the American College of Surgeons and the New York Obstetrical Society[5] are:

1. Adequately trained obstetrical personnel, the entire nursing staff to be chosen specially for work in this department and not permitted to attend other cases during their time on obstetric service.

2. Readily available, adequate laboratory and special treatment facilities under competent supervision.

3. Accurate and complete clinical records on all obstetric patients.

4. Thorough analysis and review of the clinical work of the obstetrical department

each month by the medical staff with particular consideration of deaths, infections, complications, or such conditions as are not conducive to the best end-results.

5. Adequate theoretical instruction and practical experience for student nurses in prenatal, parturient and postpartum care of the patient, as well as the care of the newborn.

In the newspapers on June 3, 1934, it was reported that the Health Commissioner of New York had appointed an advisory obstetric council of eighteen leading obstetricians and gynecologists from the five boroughs to "make a complete study and survey of all maternity hospitals, the scope and method of prenatal care, as well as a check-up on midwives and everything else that has to do with the problem".

We shall have to investigate the private or proprietary hospitals, of which there are not many in our States as compared with the 117 in New York City. We may be able to tactfully persuade these hospitals to help us and to set some mark of approval on those that keep up to certain standards.

Last year at the State Society meeting Dr. Williams[10] read a paper on maternal mortality. In May, 1934, Dr. Holmes[11] of Chicago told of the serious results of operative obstetrics in unskilled hands, and then on June 14th, at the American Medical Association meeting in Cleveland, Dr. Watson read a paper entitled "Practical Measures in the Prevention and Treatment of Puerperal Sepsis".[12]

It is wise for hospital executives to know the facts about maternal mortality, and necessary to take the proper stand in preventive measures.

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HEMORRHAGIC BLOOD DYSCRASIAS

SYMPTOMATOLOGY, DIAGNOSIS AND TREATMENT

By HYMAN I. GOLDSTEIN, M.D., Camden, N. J.

Read before the Pediatric Section of the Medical Society of New Jersey at the 168th Annual Meeting, in Atlanic City, June 6, 1934

Hemorrhage and pain have been the two symptoms from which man in his earliest history sought relief. Of these, hemorrhage perhaps has always demanded the greater, more earnest, and more immediate attention.

HEMOPHILIA

Hippocratic, Galenic and Talmudic medicine abounds in many references to bleeding, its significance, diagnosis and treatment.

Thus, we note the earliest references to hemophilic bleeding in the Babylonian Talmud (140—163 A. D.) by Rabbi Yehuda Hanassai (Jebamoth 64 b.) wherein it states that "if a woman has her first child circumcised and he dies, and again a second, then she need not have the third son cut, and if two children of the same mother or a child of each of two sisters die in succession as a result of circumcision, then the third child need not be circumcised."

Rabbi Simeon ben Gamaliel ruled also that the fourth child need not be circumcised. This scholar says a boy shall not be circumcised

when two sons of his (maternal) aunt have bled (to death) from circumcision.

Maimonides (Rambam, 1135—1204), of Cordova in Mishna Torah, Yad-Hazzaka, Hilcoth Milah (Chapt. I, Law 18) says "A woman whose first son is circumcised and dies therefrom, and then likewise the second son, whether he be of the first or second husband, the third son need not be circumcised (on the the eighth day)—but this should be delayed until he grows up to be strong."

Rabbi Moses ben Maimon Rambam—talmudist and physician, Maimonides (the "second Moses"), probably was not aware of the reference of Albucasis (1013—1106), also of Cordova, (at Zahra), in his "Liber Theoricae Necnon Practicae Alsaharavii in Prisco Arabum Medicorum. (Translated from Arabic by Paulus Ricius, Augsburg 1519) to hemophilic bleeding. Albucasis reports "a strange happening" (Mirandu accides): "On the disease of a flow of blood from any source (in a certain locality)" in Capitulum XV "De passione fluxus sanguinis a quoque locorum". He saw in "Alkira", in a certain district, *men* who bled from wounds continually until they died and that their children, when gums were rubbed (with the hand), blood began to flow from them, until they died! Another who had his vein cut by a blood-letter did not cease bleeding until he died. "And generally their death as in the great majority (in this tribe or group) occurs in this way. This is a thing which I have never seen anywhere except in the above mentioned locality (hut) nor have I found this occurring in any of the ancient works (commentators). I do not know its cause, and what seems to me to deal with its cure is that the one to whom this happens should quickly and without delay cauterize the place, until the bleeding is checked. This is all very strange to me!" ("est apud me monstrum").

It is to be noted that Maimonides speaks of the mother and not the father. This is a clear notion of maternal heredity—as he says, a boy whose two brothers on his mother's side, even if of different fathers, died of the circumcision, he need not be circumcised. But the sons of a man whose two sons died of circumcision should be circumcised when they are *not* the children of the *same mother* whose sons died following circumcision.

Rabbi Alexander Suslin Ha-Kohen, of Frankfort, talmudist and Rabbi in Cologne, Worms, and Frankfort (died sometime before 1394), author of "Aguddah" (Collection) says a man lost two sons following circumcision, then his wife (mother of these sons) died; he married another and had a son and it was ruled that according to the Talmud the blood comes from the mother (maternal heredity in these fatal bleeding cases) and therefore this man's third son was circumcised and he survived (proving that this father and the second wife were not conductors of the "bleeding disease".)

Another early reference to "hemophilia" is credited to Phillip Hoechstetter (died in 1635) whose report appears in Observationum Medicinalium Decades Sex written in 1627 (Francoforti et Lipsiae 1674) probably deals with chronic purpura hemorrhagica or chronic hemorrhagic thrombopenia, as he speaks of a newborn boy bleeding copiously from an improper binding of the navel, and who when grown up became especially prone to severe attacks of nosebleed. At the age of nine, he bled so much it frightened his on-lookers and black and blue or blood-red marks sprang up everywhere over his skin, on the face, chest, back and limbs. "In his eleventh year when he similarly bled, I opened a vein to good advantage, not fearing his tender age". (Casus Nonus: Nati Modo Sanguinem Larguis umbilicus et Adulti ad haemorrhagiam pronae nares cum suggilatione—Decades Sex, pages 170-171).

Rudolf Virchow (1863) mentions Phillip Hoechstetter's volumes of 1627 and 1674 as containing a reference to a hemophilic in Decas II, Casus Nonus. However, there is definite mention of purpuric spots: "Sugillataque seu maculae sanguinae rubrae post caeruleae per cutim passim effloruere, in facie, pectore, dorso, artubus, quae tandem flavae factae disparuere."

Alexander Benedictus (died at Padua, 1525) in his Omnium Vertice Ad Calcem Morboru signa, causae, indicationes & remediorum

(Basileae per Henricum Petrum 1539), Book IV, Chapter IV, page 203, speaks "on the flow of blood from the nose", and in this report describes the case of a certain Venetian barber who, while cutting annoying hairs on the nose, accidentally cut a small vein and "the blood burst out with such pressure that a large number of physicians failed to find a method of stopping it and the man died in a pitiable condition from the uncontrollable loss of blood."

Many writers also credit Fordyce (Fragmenta Chirurgica & Medica, pp. 41-42, 1784, T. Cadell, London) with the report of a hemophilic family, in his article on "Haemorrhagia". A bugler (Hay) of the 3rd praetorian cohort, was in the habit of bleeding almost to death's door from very slight punctures or slight blows. Styptics of all sorts were of no avail. The hemorrhages always stopped of their own accord. Whenever this man was only slightly wounded in the gastrocnemius muscles, the hemorrhage began so quickly that the blood made its way everywhere into the spaces between the muscles. Fordyce entirely checked this hemorrhage by drawing the wound apart as much as nine digits. "This, with the best approval of other surgeons and physicians. Repeated doses of bitter cathartic Epsom salt are more effective for stopping hemorrhage than any other noted astringents. This I owe to Frederick Hoffman, respected by all who are interested in human health". He further refers, at the beginning of this report, to a certain man named Laston, of Duddington, who bled almost daily from the nose. *Everyone* born here in this town (or family) was similarly afflicted. The second oldest *daughter* of the man, weakened by the same affliction, died from the uncontrollable hemorrhage. "Rarely are examples of this sort found". ("Guidam Laston, apud Duddington in comitatu Northamptoniensi; sanguis fere quotidie per nares erupit. Eo nati omnes similiter dolebant; filiaque ejus a majore proxima, eodem affectu extenuata, diem suum obiit. Hjusmodi raro dantur exempla".) It is evident that this early report of heredofamilial epistaxis referred to nosebleeders of both sexes, and is therefore, perhaps, the earliest reference to familial epitaxis in the literature.

Other early writers on the subject are: Otto (1803), of Philadelphia; Hay (1813); Nasse (1820); Schönlein (1828)—who gave the name "*hemophilia*" to this bleeder's disease was probably not informed of the character in John Ford's (born 1586) play "The Broken Heart" (1633) called "Hemophile", one of the courtiers who was interested in blood-letting and who was also called "Glutton". Banyer (1743); the author of Medicinischen Ephemeriden (Chemnitz, 1793); Rave (1798); Coxe and Smith (1804); Boardley; Rush, Rogers; Alexander Murray (1826, cases of familial epistaxis or "hemophilic" purpura); Elsaesser (1826); Coates (1828); Hartlaub (1833); James N. Hughes (Oct. 1833); Jonathan Osborn (July 1834), and Grandidier (1832, 1839, 1855).

Consbruch, of Bielefeld, in "Eine physiologische und pathologische Merkwürdigkeit" (Hufeland's Jour. der practischen Heilkunde, Vol. 30: V. Stück, No. 6, pp. 116-117, May 1810, Berlin) reports a family in which the male children suffered from epistaxis, and were notably subject to dangerous hemorrhages following the slightest wounds. Two children died from uncontrollable bleeding. The female children and their parents were entirely free of this sad affliction (idiosyncrasy).

C. L. Birch (1933) quotes Consbruch (Medicinische Ephemeriden, 1793, Chemnitz) as reporting the case of "an eleven-year-old boy who two days before had cut his thumb and without being able to stop the flow of blood by any means bled to death. A brother of this boy several years before had likewise bled to death from a slight wound. Several brothers of the mother had died in the same way. All of the females in the family are so far as I know free from this unfortunate idiosyncrasy". This description of a hemophiliac family was ten years later followed by John C. Otto's "Account of an Hemorrhagic Disposition Existing in Certain Families".

Hen. Banyer (Read Dec. 22, 1743:—"An extraordinary Haemorrhage"—Philosophical

Transactions IX, Chap. V, pages 193-194, 1732-1744), reported that "in January 1729, Daniel Goddard, a gardener, age 24, at Wisbeck in the Isle of Ely, Cambridgeshire, had a slight puncture from a rusty nail in the sole of his right foot and altho no tendons or large blood vessels were wounded, the whole foot was immediately swollen and two days later a small incision (of capillary veins) was made causing uncontrollable hemorrhage, he also had hemorrhage from the nose. He had repeated hemorrhages from the nose, from the intestines by stools and habitual hemorrhage from the kidneys and urinary passage. He died in March 1738, after a slight wound on one of his legs, from hemorrhage—"from too much Redundancy of Blood." "It appears to be a very extraordinary simple plethora". For four years to Banyer's knowledge "This Flux of Blood came from the Nose and Intestines".

PURPURA HEMORRHAGICA

Robert Willan (1757-1812) in his great work "On Cutaneous Diseases" (1796-1808) which was completed by Bateman, described perhaps the first case of Henoch's purpura (with visceral symptoms), and gave the name *"purpura hemorrhagica"* to Werlhof's disease (1801). Purpura hemorrhagica or non-pestilential (afebrile), idiopathic or essential hemorrhagic thrombopenia was probably noted by Fracastorius (1546), Ingrassia, Lazarus Riverius (1589-1665) in 1646, Amatus Lusitanus (Joh. Rodriguez, 1556), Lentilus Rosinus (1657-1733), Culpeper (1646), Eugalenus (1658), Diemerbroeck, Rombergius and others long before Paul Gottlieb Werlhof (1699-1767) described in 1735 (published 1775, Hannover) "Morbus Maculosus Werlhofii." Sauvages described this form of the disease as stomacace universalis and purpura simplex as phoenigmus petechialis Dolaeus, Zwingerus, Gregorius Horstius, Graff (1775), Adair (1789), Parry and Bateman and P. Rayner (1827, 1833) reported early instances of purpura hemorrhagica. Hornung (1734) spoke of simple, febrile and scorbutic purpura, while Raymann (1752) called afebrile purpura "petechiae mendaces". Schönlein (1829) spoke of purpura hemorrhagica or peliosis Werlhofii, peliosis senilis and peliosis rheumatica (1837).

Henoch in 1868 described "Henoch's (afebrile) purpura" with joint symptoms, vomiting, abdominal pain and intestinal hemorrhage, and in 1887 he termed the rapidly fatal type "purpura fulminans" (associated with meningococcic infections, etc.) Adair (1789) gave the name "Haemorrhoea petichialis" to the chronic form of purpura. Rombergius (about 1725) and Graff (1775) discussed the chronic form of purpura as "petechiae sine febre" while Amatus Lusitanus (1556) spoke of this condition under the title "Morbus Pulicaris Absque Febre". Cusson called it "purpura apyreta", while Pezoldus and Zwingerus treated it under the name of "maculae nigrae sine febre".

CLASSIFICATION

Classifications of the various hemorrhagic blood dyscrasias have been suggested by Glanzman (1916), Frank (1925), Guglielmo (1926), N. Rosenthal (1928), Morawitz (Leipzig), and others.

Morawitz's etiologic classification (slightly modified) may be helpfully used as a guide in the differential diagnosis of the many hemorrhagic dyscrasias:

I. *Avitaminoses* (Scorbutus and Möller—Barlow's Disease).

II. *Nutritional Disturbances*: (a) purpura senilis. (b) purpura cachecticorum (as in gastric carcinoma and bone metastases)—(may be included in VI b.)

III. *Heredofamilial* (and endogenous type): (a) Hemophilia. (b) "Pseudohemophilia"—[thrombasthenia (Glanzmann, Kromeke), fibrinopenia, constitutional thrombopathy, afibrinogenia (Opitz and Frei, 1921, chiefly in females), hypocalcemia]. (c) Essential thrombopenia (Frank) or hemorrhagic thrombopenia. (d) Rendu-Osler-Weber's Disease (Goldstein's heredofamilial angiomatosis with recurring epistaxis). (e) Endogenous Angiorrhexis (in women). (f) Bernuth's pseudohemophilia or anemia. (g) Prothrombinemia (acute and chronic). (h) Hemorrhagiparous hemotrypsia (Chevallier 1924, Clerc & Levy

1926, Emile-Weil 1930). (i) Hemophilia acquisita.

IV. *Hormonal Type*: (a) Thrombopenic and athrombopenic purpura in prämenstruum. (b) The same in the climacterium (rare). (c) In males (uncertain). (d) David's Disease (Ovarian deficiency in women).

V. *Infectious Type*: (a) Thrombopenic and athrombopenic purpura in known infectious diseases. (b) Purpura epidemica without known etiologic disease. (c) Urticaria hemorrhagica (Stuhler 1930).

VI. *Toxic Type*: (a) Purpura from chemical poisons (benzol, salvarsan, phosphorus, bismarsen, goldtherapy, sedormid, quinine, ergot, potassium iodide). (b) Purpura due to autointoxication (as in liver insufficiency, uremia, severe circulatory disturbance, tumors). (c) Purpura due to unknown poisons: 1. Schönlein-Henoch purpura; 2. Purpura Majocchi; 3. Purpura fulminans.

VII. *Purpura in Blood Diseases*: (a) Anemias (Banti's Disease, aplastic anemia, pernicious anemia, etc.). (b) Leukemias. (c) Lymphogranulomas (Hodgkin's Diesase, etc.).

DIAGNOSIS

In the diagnosis of *hemophilia* and *thrombopenias* one must remember that we sometimes meet with mixed, or transitional, and atypical cases. *True hemophilia* is a sharply differentiated clinical entity. It is characterized chiefly by a normal or nearly normal bleeding time, its restricted occurrence in males (although many writers have reported instances of bleeding hemophiliac females), its hereditary transmission according to the so-called Lossen's law, the absence of demonstrable vascular changes, a normal morphologic blood picture, and *markedly prolonged coagulation time* pointed out by Sahli and others. This last and basic differential symptom is no longer considered as characteristic and as the single pathogenic factor in hemophilia. This is not explained by fibrinopenia, afibrinogenia or hypocalcemia, although Hess has described a case of hemophilia with a calcium deficiency in the blood. Klinger and Hess, and others have observed in some transitional forms of hemophilia, in addition to the hemophilic symptoms, also evidence of thrombopenia. Perhaps some hereditary vascular factor as well as a hormonal factor play a part in hemophilia. We now know that the hemophilic thrombocytes are abnormally resistant and "pachydermically tough". When traumatized hemophilic blood platelets will function normally. It is therefore accepted that there is a definite thrombopathy with resulting platelet dysfunction because of this undue resistance, in hemophilia.

Essential hemorrhagic thrombopenia or Werlhof's purpura hemorrhagica of unknown etiology, and unassociated with any other disease-picture, is diagnosed chiefly by the great reduction or nearly total disappearance of thrombocytes, the characteristically prolonged bleeding time, decreased or absent clot retraction and normal primary coagulation time. One must remember that we not uncommonly meet with cases of "purpura hemorrhagica" without purpuric lesions, but with severe prolonged hemorrhages and thrombopenia. It has therefore been suggested (McLean, et al., Jan. 30, 1932) that a better name for this hemorrhagic disease would be "hemorrhagic thrombocytopenia".

Mills (1926) found no increase in antithrombin in hemophiliac blood or serum and believes the fault in hemophilia concerns the prothrombin factor. He found that protein sensitization and local skin reactions in hemophiliacs tended to generate a normally reacting prothrombin and he therefore suggests that hemophilia be treated by sensitization of the patient.

Prothrombin-time (Howell) is delayed in true hemophilia due to a decreased prothrombin content—90 to 300 minutes instead of 9 to 12 minutes (normal). Prothrombin-time is normal in purpura hemorrhagica. It may be delayed in some cases of *melena neonatorum*.

Zatti and Miralgia (1926) have found that in those conditions in which the coagulation-time is increased, the catalase content of the blood is also decreased, and so they infer that those diseases which affect the reticulo-endothelial system affect both the catalases and the ferments of coagulation. So that we have markedly prolonged bleeding-time (Duke) in

purpura hemorrhagica (normal bleeding time in typical hemophilia), and greatly reduced blood-platelets, lowered fibrinogen content of the blood as the result of which clots are soft and fragile and fail to contract resulting in hemorrhages, despite normal coagulation time. Normally, clot retraction is complete in 18 to 24 hours.

In *hemophilia*, the formation of a clot is much retarded, but once formed it contracts normally. In *purpura hemorrhagica* the clot forms normally in a few minutes, but contractility of the clot is not evident, even for days.

It may be suggested that further studies be made concerning thrombocytic and leucocytic fragility and the significance of motile elements in the blood (kinetocytes). It has been indicated that *kinetocytes* have been found to be increased in thrombocytopenic hemorrhagic disease. Howell and Cekada (1926) have studied fragility of the blood-platelets. Howell regards the platelets as the chief source of thromboplastin. The entire function of the blood-platelets in the coagulation process is not yet known.

In *athrombopenic purpura* as met with in infections, anaphylaxis, and rheumatic conditions clotting is normal or only slightly altered, bleeding time is normal or slightly prolonged and blood platelets are normal in number.

It is possible to explain lowered blood-platelet counts in some atypical ("pseudohemophilia") cases by the use of thrombocytes in endeavoring to repair defects in the walls of developmentally defective bleeding blood-vessels.

Hans Opitz and Magda Frei (1921) have described a new form of "*pseudohemophilia ex afibrinogenia*" occurring sporadically, females being also affected. This condition is characterized by a total absence of fibrinogen, complete non-coagulability of the blood, sporadic occurrence and female susceptibility. They report a case of a female child of 8½ months with a tendency to hemorrhage, bloody vomiting, bloody stools, appearance of "blood-blisters", slight epistaxis, prolonged coagulation-time, prolonged bleeding-time and signs of moderate rickets.

Emile-Weil (1930), Chevallier (1924), and Clerc and Levy (1926), have reported cases of *hemorrhagiparous hemotrypsia*. An accident or an operation may cause a hemorrhage in an otherwise normal individual. This hemorrhage is then followed by another or a series of hemorrhages. Thus, in certain cases the accident or operation caused the hemorrhagic diathesis. Hemotrypsia may be produced by interstitial (subcutaneous or intramuscular hematoma) hemorrhage or by an external hemorrhage. In several cases, the first hemorrhage caused a hemorrhagiparous condition, a hemorrhagic purpura which continued for a long time with resulting severe anemia. It seems that an incubation period is necessary, varying from several hours to a week. It is stated that hemotrypsia only appears in patients who have a chronic hemorrhagic diathesis characterized by lesions of the blood and capillaries and manifested by an increase in the bleeding-time, a decrease in thrombocytes, irretraction of the clot and sometimes a considerable delay in coagulation time. All of these patients have an instability of the blood. This condition may occur in acquired hemophilia and only exceptionally in familial hemophilia.

Von Willebrand and Jürgens (1933) described a new hemorrhagic diathesis which they designate as "constitutional thrombopathy". One of the authors observed this diathesis several years ago in a girl, aged 4. The child had extensive hemorrhages in the skin and in the mucous membranes and almost uncontrollable hemorrhages from the nose and the gums. Examination of the blood revealed thrombocytes of normal number and shape, normal coagulation and good retraction, but *considerably prolonged bleeding time*. More extensive investigations showed that this disorder was familial and hereditary. In three families that were studied, numerous members showed signs of this hemorrhagic diathesis, which could be traced back four generations. Both sexes were affected, but women somewhat more frequently and more severely than men. The most frequent form of hemorrhage in this condition is *nosebleed*, to which nearly all these patients were subject at some time or

other in their life, generally during childhood or puberty, but occasionally during the menopause. Hemorrhages from the gums are another characteristic symptom, and often give the impression of a scorbutic condition. The prolonged hemorrhages after slight injuries resemble greatly those of hemophilia. However, the blood picture, particularly the number of thrombocytes, is normal. The morphology of the platelets is largely normal, but the authors noted that there *were more large ones than is normally the case*. Moreover, in spite of the normal number of platelets, the thrombosis time (measured in the capillary thrombometer according to Morawitz and Jürgens) was enormously prolonged. In the case of the little girl it was more than ten times the normal length. They consider this deficient thrombus formation and changes in the blood fluid the essential factors of constitutional thrombopathy. The coagulation time of the blood is entirely normal, and this factor puts the discussed hemorrhagic diathesis in direct contrast with hemophilia. It differs from essential thrombopenia in that the number of platelets is not reduced. In *Glanzmann's thrombasthenia*, the bleeding time is normal, pathologic forms of platelets are regularly found and retraction of the blood clot is abolished, which proves that it is a disturbance of the last phase of the coagulation process. The described constitutional thrombopathy, however, is essentially *a functional disturbance of the platelet apparatus*. They consider blood transfusion the most effective treatment of this form of hemorrhagic diathesis.

Rendu-Osler-Weber's Disease or Goldstein's heredofamilial angiomatosis with recurring epistaxis has been discussed by Rendu (1896), Osler (1901, 1907, 1911), Weber (1907, 1924), Ullman (1900, 1930, 1932) and Goldstein (1921, 1930, 1931, 1932, 1934), and many others. The condition has no doubt been overlooked by many of us. Recent increasing reports would indicate that this clinical entity is now being recognized and is being more often considered as a possible diagnosis in the study of hemorrhagic diseases.

The condition was first definitely separated from hemophilia by Rendu, of Paris, in 1896. About 120 cases (families) have been recorded in the literature, including about 750 or 800 affected individuals.

This clinical entity is characterized by oft-repeated attacks of epistaxis (telangiectasia), angiomatosis, and the familial incidence of the disease. The condition is not sex-bound, both males and females are similarly affected and it is transmitted by both sexes. The blood is usually morphologically and chemically normal except for the presence of secondary post-hemorrhagic anemia. Clotting and bleeding times are normal. Thrombocytes are numerically and qualitatively normal. Telangiectases may be noted on the face, lips, tongue and septum of the nose, and they may be few or many in number.

TREATMENT

During recent years protein sensitization (Vines; Eley and Clifford; Marlow; Mills), the intravenous use of maternal blood serum (Chalier; Puech), ovarian substance and female sex hormones (Grant; Bertarelli; Himmelstjerna; Kimm & Van Allen; Rypins; Paul Niehans; Carroll Birch; Foord and Dysart; Goldstein), bothropic antivenin (Taylor; Stockton and Franklin), moccasin snake venom (Peck and Rosenthal, New York), special high protein and fat diet (Kugelmass), rich vitamin diets (Morawitz; Ziegelroth, 1928) of fruits, vegetables, eggs, organ tissues—lung, kidney, brain, *liver*, pancreas—irradiated ergosterol, Wright's calcium therapy, intravenous injections of congo-red solution, deep x-ray therapy over the spleen (to check thrombolytic activity) and liver (to stimulate fibrinogen and prothrombin formation) have all been recommended and tried with varying results. Kugelmass advised dietary regulation and treatment of the mother throughout pregnancy and the careful study of her bleeding and clotting times (and thrombocytes) and thus, perhaps, help to prevent blood dyscrasias in the newborn. It has also been suggested (Warwick, 1922) that the bleeding and clotting times of all newborn infants during the first eight days be studied. Bernstein (1932) treats hemophilic

joints with whole blood from menstruating women.

Hemophilia. Kugelmass (1934) in his latest contribution to the subject of "Clinical Control of Chronic Hemorrhagic States in Childhood" calls attention to ovarian *dysfunction* as a not uncommon cause for the genesis of thrombopenia. He noted a diminution of platelets during menstruation, increased capillary permeability with ovarian deficiency, preponderance of thrombopenia in females, as favoring the administration of ovarian therapy in such cases.

Birch (1931) confirmed Howell's suggestion that the trouble in hemophilia lies in the platelets, which although morphologically normal in number and structure, fail to yield the cephalin necessary for the clotting process to go on normally. Birch found in two hemophiliac brothers that the platelets were much more resistant to anisotonic salt solutions than were normal platelets. It has been emphasized by Lachlan Grant (1904), Samson-Himmelstjerna (1925, 1926, 1934), Gonzalez-Alvarez (1925), Neihans (1930), Birch, of Chicago, and others that the ovarian and female sex hormones play an important part in rendering the females of hemophilic families free from the tendency to severe recurring hemorrhages and this would indicate the advisability of the use of ovarian and sex hormone preparations in the treatment of male bleeders. A number of favorable reports have appeared in the literature during the past three years.

Recently, Stetson, Forkner, Chew and Rich (Jour. A. M. A., p. 1122, April 7, 1934) have reported on the "Negative Effect of Prolonged Administration of Ovarian Substances in Hemophilia". They failed to note any improvement that could be attributed to ovarian therapy.

Brem and Leopold (Jan. 20, 1934, J. A. M. A.) conclude that they have not been able to demonstrate the presence of the estrogenic substance in the urine of normal males. If the female sex hormone holds hemophilia in abeyance, it should be present in the urine of all normal males rather than in isolated cases. The commercial estrogenic substance employed by them, of known potency, failed to reduce the coagulation time of the blood or stop the several hemorrhages in their hemophiliac patient. Symptomatic treatment and blood transfusions in their opinion are still the methods of choice in hemophilia.

The hemophilic type of blood dyscrasias are much less common than the purpuric group of hemorrhagic disease. The latter being frequently a complicating factor in bone marrow diseases leading to depressed or abnormal megakaryocytic production and function in leukemic, aleukemic and lymphogranulomatous processes, and in the large group of allergic diseases.

Given a patient with *chronic essential hemorrhagic thrombopenia* (thrombocytopenic purpura) with a *marked capillary resistance test* [Weill (1911), Grocco-Frugoni's sign (1911), Rumpel-Leede phenomenon (1911), Hess (capillary resistance test, 1914)] or "le signe du Lacet", marked diminution of the thrombocytes or "hematoblasts" [Krauss (1883), Denys (1887), Hayem (1890)], non-retractility of the clot (Hayem 1896), prolonged bleeding-time [Stoker (1823), Henoch (1882), Duke (1910)], a normal or only slightly delayed clotting time and a moderate leucocytosis and some evidence of erythropoiesis, there should be no delay in administering blood transfusions, autohemotherapy (Nägeli), x-ray therapy of the spleen and liver and instituting a dietary rich in proteins, fats and vitamins. *Nutritional therapy* as suggested by Kugelmass, Morawitz, Ziegelroth and others will greatly aid the patient to overcome the blood deficiencies in thrombocytopenic hemorrhagic dyscrasias.

The effectiveness of *splenectomy* as originally suggested by P. Kaznelson (1916) to inhibit spleno-thrombolytotoxic activity is limited chiefly to chronic essential hemorrhagic thrombocytopenia and other similar conditions leading to megakaryocytotoxicosis or disturbed bone-marrow function. In cases with granulopenia and leukopenia splenectomy is contraindicated. Splenectomy, while not always helpful or life-saving in essential thrombocytopenia, is certainly saving the lives of some of these patients, who formerly died as the result of the great blood-loss and resulting severe

anemia, when the hemorrhages were due to depressed bone-marrow activity or some disturbance or lesion (non-malignant and non-metastatic) causing megakaryocytic hypofunction or dysfunction (McLean, Kreidel, Caffey, J. A. M. A.; Jan. 30, 1932). Ligating the splenic artery has been tried with some degree of success.

In *Giffin's subleukemic splenic reticulosis* (1934) retractility of the clot is absent for many hours and is associated with a normal bleeding-time and a marked thrombocytopenia, macrocytic anemia, splenomegaly, and purpuric features are noted. In the blood, after careful search, one finds reticulo-endothelial cells or the reticular type of monocytic cells in the blood smears. There was slight tendency to hemorrhage in Giffin's patient, a man 50 years of age.

Reference might here be made to the treatment of true *melena neonatorum* as suggested by Kugelmass in his paper on "Prenatal Prevention of Potential Hemorrhagic Disease of the New Born" (J. A. M. A. 92; No. 7, pp. 531-532 [Feb. 16], 1929) in which there is a marked decrease in the prothrombin content of the infant's blood associated with a progressively prolonged clotting time of the blood and gastrointestinal hemorrhages. He states that prothrombin and fibrinogen are protein substances in the plasma and that their concentration in the blood of both mother and child may be increased by high protein ingestion. He therefore suggests a high protein and fat dietary to be instituted, as a prenatal precaution, for the mother throughout her pregnancy if there is a history of previous instances of melena neonatorum. The platelets, he states, are lipoidal protoplasmic separations from megakaryocytes and the platelet content of the blood may therefore be increased by a relatively high fat diet. He concludes, correctly, that the valuation of the blood-clotting function of (pregnant) maternal blood thus offers a basis of prediction of potential hemorrhagic disease in utero.

Eliason and Ferguson (Ann. Surg. Nov. 1932) state that it has not yet been proven that the spleen is the organ at fault in purpura hemorrhagica and that there is a disturbance of the entire reticulo-endothelial system and not only a reduction of the blood platelets in this disease. Splenectomy, from their experience and a review of the literature, appears to be the most effective method of controlling extensive hemorrhage in purpura hemorrhagica of either the acute or recurring type. However, in acute purpura, there were thirty-five cases treated by splenectomy with twelve deaths, 34.3 per cent, and in the chronic purpuras there were 160 cases of splenectomy collected from the literature with 11 deaths, 7 per cent. The operative mortality for the whole group (213 reported cases) was 13.1 per cent, but in the cases collected from the last four years the mortality is only 7.08 per cent in 113 cases.

The treatment in the rare cases of *Glanzmann's hereditary thrombasthenic purpura* and in Van der Zande's familial (not sexbound) thrombasthenia, as well as the treatment of "constitutional thrombopathy" (Willebrand and Jürgens), consists chiefly of the use of autohemotherapy, blood transfusions, and perhaps x-ray therapy, with Peck's snake venom or treatment by anaphylaxis presupposing, of course, that the patient has already been rendered sensitive to a specific antigen.

In closing this general review on the subject of hemorrhagic blood dyscrasias, one is forced to the conclusion that much has been learned during the last quarter of a century, particularly as to the more exact classification of the various hemorrhagic diseases, and their treatment. However, it must be admitted that there is much yet to learn from the etiologic and therapeutic view-points. The results of our present advances in the treatment of the various blood dyscrasias, while certainly encouraging, are still far from satisfactory. There is still left a vast field of undiscovered information necessary for the proper understanding of this all-important group of hemorrhagic diseases. Let us hope that the many researches now being so actively carried on in this and other countries of the world will, in the near future, bring us into a clearer field of broader understanding of these many puzzling questions.

SINUSITIS IN CHILDREN

By Lyman Richards, M.D., Boston, Mass.

Abstract of an illustrated lecture delivered before the Section on Laryngology of The Medical Society of New Jersey, in Atlantic City, June 6, 1934.

The last ten years has seen our knowledge of sinus disease in children systematized and clarified, and its treatment standardized. It is now a well-established fact that infants have certain sinuses developed at birth, capable of becoming involved in pathological conditions.

Sinus disease, like that of any other part of the body, is influenced by constitutional conditions, such as diet, vitamin intake, endocrine deficiencies, sunlight, and exercise. All these require attention in order to produce a cure.

A diseased sinus may also be a center of focal infection producing disturbances in the gastro-intestinal tract, the respiratory organs, and the circulatory and urinary systems.

This article deals principally with treatment, and an evaluation of the common therapeutic procedures.

Disturbances of the sinuses may be divided into three major groups:

1. Acute infectious sinusitis.
2. Chronic infectious sinusitis.
3. Allergic sinusitis.

ACUTE INFECTIOUS SINUSITIS

Acute infectious sinusitis is nearly always the result of an extension of a common cold. Some clinicians suppose that the antrum is always involved in a "cold" of any degree of severity. A continuation of the antral symptoms and fever is usually the result of retained secretions. Treatment consists in nasal shrinkage and ventilation; but if these are not effective, and the x-ray, and the temperature chart indicate retained pus under pressure, then puncture, aspiration, and irrigation are usually indicated, the methods to be determined by the judgment of the operator.

A bacteriological examination of the washings may disclose the offending organism. In some instances the pathogenic organisms may be within the membrane of the sinus, but radical removal of the lining is unjustifiable in most children.

Two forms of fulminating infection of the antrum require special consideration:

1. An involvement of the superior maxillary bone.
2. Ethmoiditis with an abscess of the orbit.

In the involvement of the maxillary bone the picture is that of an osteomyelitis—high fever, swelling of the external soft parts, and severe toxemia. This condition requires active treatment, but even here zeal is to be tempered with conservatism. A disturbance in dental development is likely to follow the osteomyelitis.

The second fulminating condition is that of an acute ethmoiditis with an abscess of the orbit. When this occurs, there will be great swelling of the eyelids, limitation of the movement of the eyeballs, and signs of intraorbital pressure. If pus has formed, it must be evacuated either by an external incision, or an operation through the nose, but here conservatism should be observed, with topical treatment through the nose. An alarming degree of symptoms may subside under this treatment, even if meningitis or septicemia is threatened. A secondary operation on the damaged ethmoid cells may be necessary.

One occasionally sees cases in which general septimecia is present, with involvement of both the antrum and the ethmoid and with embolism of the arteries and an involvement of the dura. Even here, conservatism in treatment should be observed.

CHRONIC INFECTIOUS SINUSITIS

A wide difference of opinion exists in regards to the pathology and treatment of chronic infectious sinusitis. Two conditions may be expected:

1. Persistent hyperplasia of the lining membrane.
2. Defective ventilation and drainage of the cavities and nasal airways.

The causes of the conditions include:

Adenoid tissue.

Deviated septum.

Hypertrophied turbinates and chronic edema of the ostium of the sinus.

The treatment consists primarily in establishing free ventilation by means of drops, irrigations, sprays, tampons, suction, and operation, each to be determined by the individual skill and knowledge of the doctor. The operations include the removal of the tip of the middle turbinate, and the removal of the tonsils and adenoids. However, a permanent cure and a temporary improvement of symptoms are not necessarily the same thing. The permanent value of removal of the tonsils and adenoids in chronic sinusitis has yet to be proved.

There are cases of chronic sinusitis with excessive hyperplasia where a cure can come only from the removal of the lining of the antrum. This is a procedure of last resort.

An x-ray diagnosis is of the utmost importance, but the films are to be interpreted in the light of clinical symptoms.

ALLERGIC SINUSITIS

Allergy in its relation to sinusitis is a recent field of investigation that has been covered with great care, but so far with inconclusive results. There are three major subdivisions of the subject which can be correlated with nasal manifestations of hypersensitiveness:

1. A pure allergy, in which edema of the mucous membrane accompanies an inhalent, as in hay fever.

2. An allergic diathesis which is complicated with a sinus infection that yet is not the cause of the hypersensitiveness.

3. A bacterial sinus infection that makes the patient hypersensitive to his own bacterial infection. In these cases if the basic cause of the allergy is discovered and treated, the nasal condition subsides spontaneously.

The treatment of sinusitis in children requires the coöperation of both the pediatrician and the laryngologist, both guided by three cardinal principles of medical practice—common sense, surgical judgment, and the study of the individual.

DISCUSSION

Dr. James A. Fisher, Asbury Park: Sinusitis in children has been a pet subject of Dr. Richards for several years and his opportunities for study and research have been extensive; therefore his findings and advice must be accepted as quite conclusive.

Given a child with a diet properly balanced, containing sufficient vitamine content, having plenty of fresh air, not over clothed and without nasal obstruction or post-nasal blockage from adenoids, and sinusitis will be a rarity unless there is an allergic tendency.

Conservatism in the treatment of sinusitis as such in children cannot be too strongly emphasized. Resort to surgery of the simplest kind to affect a cure when convinced that non-surgical measures have failed.

There are rhinologists that approve and those that condemn tamponade treatment, but I believe there is a right and wrong way to tampon. Always use a tampon of best grade cotton, very lightly wound on a smooth applicator, just sufficiently large to cause no pressure after inserting it in the full length of the middle meatus. The applicator is then removed. Cocain or other astringents should not be used preceding its application but may be employed after the treatment. I am now using either Argyrol 10 per cent in glycerine, or merthiolate and glycerine equal parts. The head should incline well forward and the treatment last one-half hour. Daily treatments are advisable and continued until there is absolutely no bleaching of the argyrol or no discharge appears on the tampon.

I very rarely resort to the use of any negative pressure, and when I do use it, I prefer to use a hand operated suction bulb.

Dr. Richards has given us an excellent outline to follow in the management of both the acute and chronic sinus cases; but the responsibility of determining when and how much to operate is still ours, and only by careful study both clinically and by x-ray will the decision be made.

KERATOPLASTY

REPORT OF CASES WITH SPECIAL REFERENCE TO COMPLICATED ONES

By Ramon Castroviejo, M.D., New York City

Institute of Ophthalmology, Columbia Presbyterian Medical Center

Read by invitation before the Section on the Eye, Ear, Nose and Throat of The Medical Society of New Jersey, at Atlantic City, June 7, 1934

SUMMARY

Experimental work on eyes of rabbits with normal and leucomatous corneas[1, 2, 3, 4] and similar work performed upon human eyes[5] have proved that homo-keratoplasty can successfully be accomplished when a suitable technique is followed. The graft for an eye of the human patient is obtained from the other eye of the patient, or from another person's eyeball that has been enucleated for a surgical condition.

The objects of this paper are:

To describe briefly the methods of transillumination used to examine eyes with corneal leucomas.

To describe in detail the technique of the operation for the corneal transplantation.

To report cases typical of conditions before and after operation.

SELECTION OF CASES

The technique of partial penetrating keratoplasty to be described will give the best results in those eyes in which the whole pathology is limited to the cornea, the leucoma is not very dense, and there are areas of non- or little-scarred cornea surrounding the transplant. The first of the cases to be reported belongs to this group of favorable eyes in which operation for corneal transplantation may be expected to give a high percentage of success. In those eyes with dense corneal leucomas, in which the transplant is entirely surrounded by dense scarred tissue, in those with aphakia (absence of lens), and loss of vitreous during the operation, hypertension, etc., the results can not be

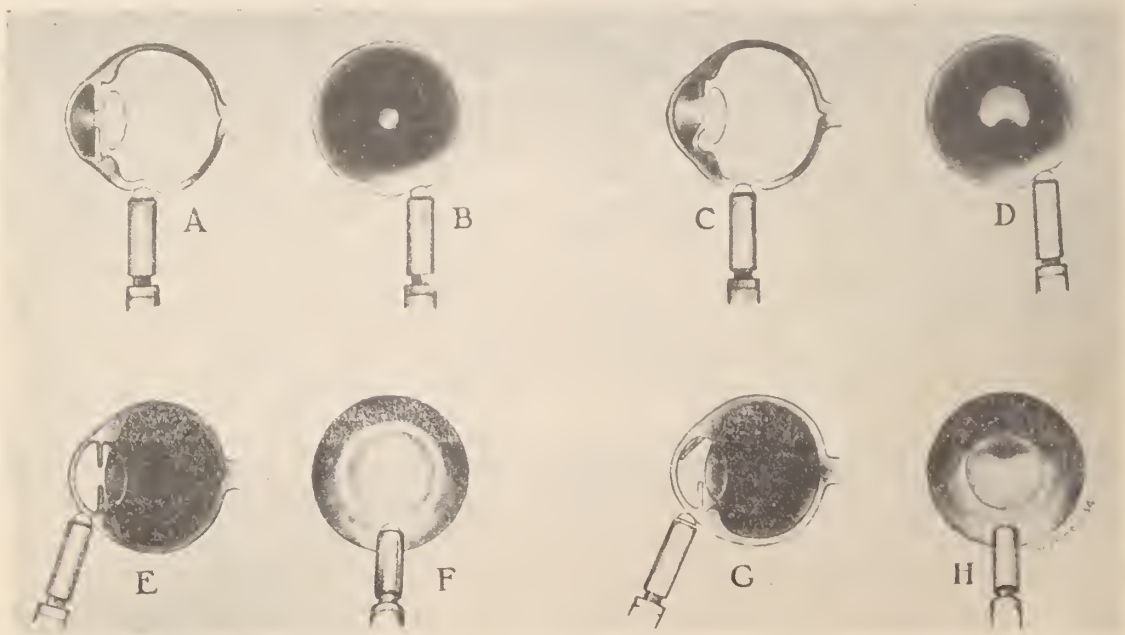


FIGURE 1

Posterior Transillumination in a Normal Eye. (A)—Cross Section. (B)—Front View.
Posterior Transillumination of an Eye with Posterior Synechia. (C)—Cross Section. (D)—Front View.
Anterior Transillumination of a Normal Eye. (E)—Cross Section. (F)—Front View.
Anterior Transillumination of an Eye with Anterior Synechia. (G)—Cross Section. (H) Front View.

expected to be so brilliant; but inasmuch as the vision in such eyes is limited to light perception and projection, or only perception, and the corneal transplantation offers the only means to improve vision, operation is advisable. The last three cases to be reported belong to this last group of unfavorable eyes to undergo a corneal transplantation.

OPHTHALMOSCOPIC EXAMINATION

In some cases of leucomatous corneas, the leucoma, although sufficiently dense to cause considerable impairment of vision, allows a good examination of the anterior segment of the eye by the ordinary means of exploration, such as the ophthalmoscope and the slit-lamp. Information is thus obtained about the thickness of the cornea, the nature of the opacity, and whether or not anterior or posterior synechia (adhesions) is present. The lens can also be examined if there are some transparent areas in the cornea.

TRANSILLUMINATION

When the leucoma is very dense, the usual methods of examination do not give sufficient information, and in such cases *transillumination* becomes the most valuable method. Transillumination can easily be performed with an ordinary electric ophthalmoscope provided with a condenser. The examination is performed in a dark room. The transilluminator can be applied on the eye behind the region of the ciliary body (Fig. 1, A, B, C and D). The light will pass through the pupil, surgical colobomas (congenital fissures) and atrophic areas of the iris and ciliary body, giving information about their shape and position. Turning the light on and off, the transilluminated pupil may either dilate or contract regularly all around, indicating a free iris; or part of it may dilate, while the rest remains immobile (Fig. 1, C, D), the immobile portion indicating the site of an anterior or posterior synechia. Absence of reaction of the pupil to light stimulation will indicate that there is a large anterior or posterior synechia.

The anterior chamber can also be examined by transillumination, using the method described by Mendoza[6] for the study of the angle of the anterior chamber. In this method, the transilluminator is applied at the limbus in front of the insertion of the iris (Fig. 1, E, F, G and H). If the anterior chamber is free from synechia, it will appear with a bright uniform illumination (Fig. 1, E and F), not only in the opaque or translucent cornea, but also at the limbus in the opaque sclera, corresponding to the region of the angle of the anterior chamber. Anterior synechias will be seen as dark areas in the illuminated anterior segment, whether they are peripheral or central (Fig. 1, G and H).

PREPARATION OF THE PATIENT

A detailed study of the patient's general condition is made, eliminating foci of infection, trying by all means to bring the patient to the operation in a normal general condition, or as near so as possible.

Smears and cultures are taken from the conjunctival cul-de-sac, but we are, as yet, uncertain as to what importance should be ascribed to the results of these cultures. Hemolytic staphylococcus aureus has been found in many cases which were successfully operated without evidence of infection. On the other hand, this organism is a frequent cause of post-operative panophthalmitis. Hemolytic streptococci and pneumococci are found less frequently, and it would probably be prudent to delay the operation when these are present.

A dose of sodium amytal is given two or three hours before the operation. Argyrol, 20 per cent solution, is instilled in the eye and the pupil dilated with a 3 per cent solution of atropine sulphate. In the presence of anterior or posterior synechias, iridectomy should be performed a few months prior to the corneal transplantation in order to liberate the iris from the area in the cornea where the transplant will be located. The transplant invariably opacifies if the iris becomes adherent to it.

Local anesthesia is preferable to general anesthesia, in that it eliminates post-operative unrest which would threaten the success of the transplantation.

INSTRUMENTS

Figure 2 shows the instruments to be used in the operation, the double-bladed knife (D), keratome (E), and scissors (G), having been especially designed for this technique. The

double-bladed knife is provided with detachable blades made out of razor blade steel. They are very sharp and should be tested in kidskin, discarding them if the points or edges are not in very good condition. The separation of the blades can be regulated to the desired width, which experience has shown to be 4 mm. If the transplant is larger than 4 mm., there is danger of incarceration of the iris between the transplant and the cornea of the recipient. If the transplant is smaller than 4 mm., the proliferation of connective tissue during the healing process might include the small central area of the transplant, with subsequent failure of the operation.

The keratome is 4 mm. wide and has been especially designed to cut accurately one of the edges of the transplant.

The special scissors are provided with dull points to avoid injury to the lens, and are shaped in such a way as to make it easy to hold them at a certain angle to obtain uniform bevelling of the edges of the transplant.

OPERATION

A routine preparation of the eye is made ten minutes before operation with a few instillations of 4 per cent solution of cocaine and solution of adrenalin, 1/1000; immediately before the operation, a 20 per cent solution of argyrol is again instilled, followed by another instillation of cocaine and adrenalin. Paresis of the orbicularis is produced, following Van Lint's technique. A retrobulbar injection of 1 cc. of 2 per cent solution of novocaine and adrenalin 1/10000 is given and a few drops of cocaine 2 per cent and adrenalin 1/10000 are injected above and below under the bulbar conjunctiva. Separation of the eyelids is maintained either with a speculum or with a cen-

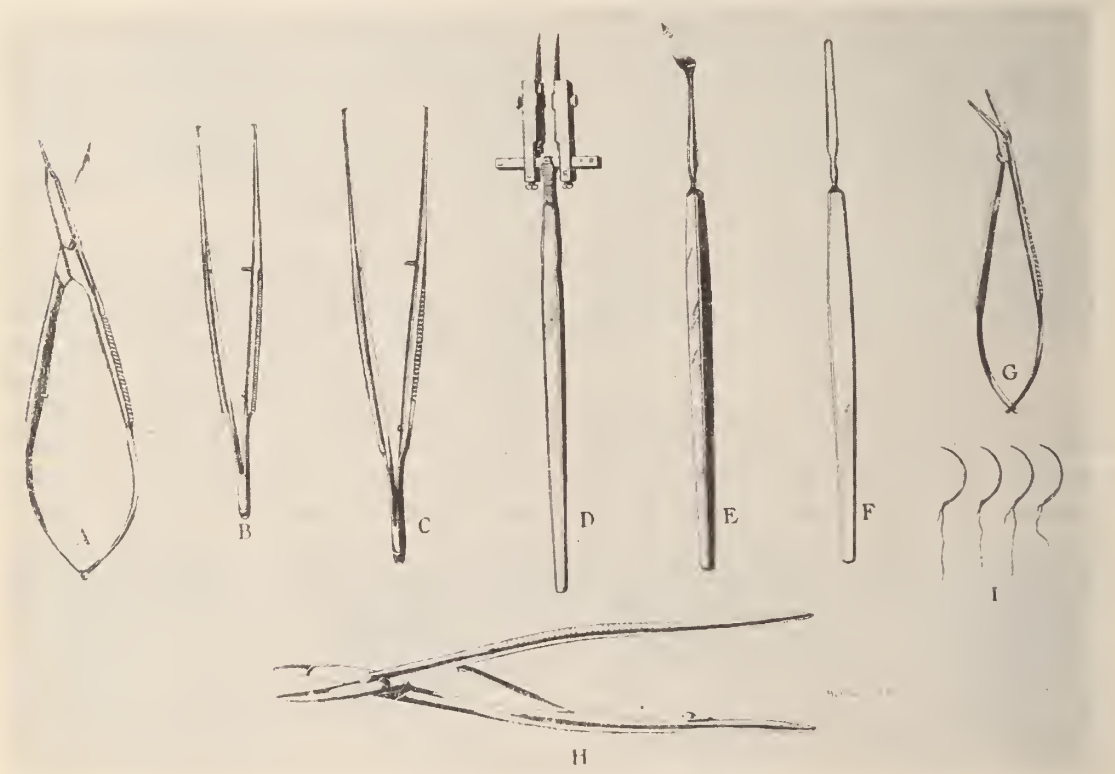


FIGURE 2

Instruments Required for Author's Technic in Partial Penetrating Keratoplasty.*
(A) Scissors. (B) Conjunctival Forceps. (C) Elschnig Fixation Forceps. (D) Author's Double Bladed Knife. (E) Author's Keratome. (F) Spatula. (G) Author's Scissors for Cutting the Cornea. (H) Author's Combination Needle Holder, Forceps and Scissors. (I) Sutures.

* Instruments are made by V. Mueller & Co., 1835 W. Van Buren Street, Chicago, Ill.

tral suture inserted in the skin of each eyelid near the eyelashes. Pulling of these sutures allows the eyelids to be separated without interfering with the different steps of the operation, as sometimes happens when a speculum is used in patients with small palpebral fissures.

Conjunctival incisions (Fig. 3A) are made above and below near the limbus, leaving two zones, one on each side of the horizontal meridian through which the conjunctival incisions do not reach.

The conjunctiva above and below is undermined until two flaps are made which can be stretched with the aid of forceps towards the center of the cornea, covering the central area from 8 to 10 mm. along the horizontal diameter. Four sutures, about 3 mm. apart, are placed in the margins of the conjunctival flaps (Fig. 3A). The flaps are drawn again over the central area of the cornea where the transplant is to be located, to be sure that the flaps cover this area uniformly and not with excessive tension. The conjunctival sutures are drawn back from over the cornea.

The eye is fixed with Elschnig fixation forceps (Fig. 3B), taking hold of the episclera below near the limbus. Then, the twin knives, adjusted to the desired separation, are used to make two vertical incisions. Changing the fixation, as indicated in Figure 3, C, two horizontal incisions are made at right angles to the vertical ones in order to outline a square flap These incisions act as guides to outline the corneal flap and are cut only from one-third to one-half the thickness of the cornea (Fig. 3,D). Care must be taken not to exert too much pressure which might lead to perforation of the cornea. Fluorescin is instilled to make these incisions stand out.

The eye is again fixed by taking hold of the episclera near the limbus (Fig. 3, E). With the special keratome, a penetrating section is made along the upper incision of the marked-

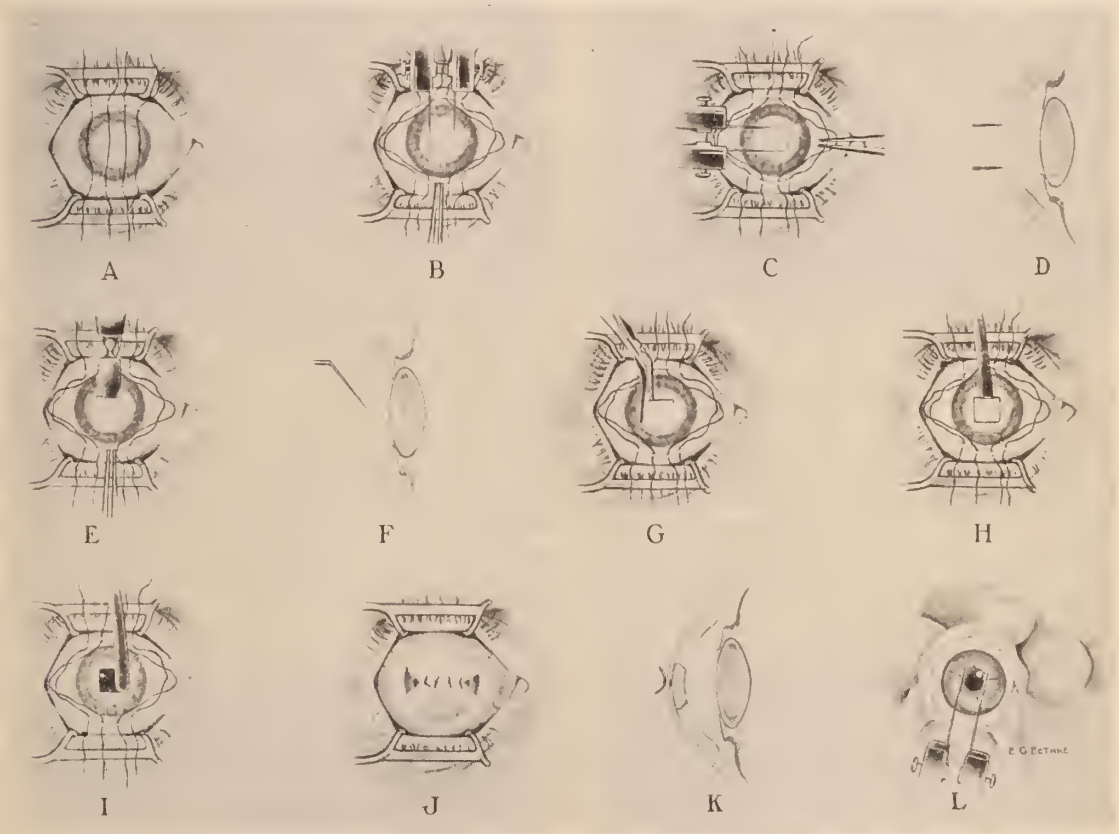


Figure 3.—Author's Technic in Partial Penetrating Keratoplasty.

out square at an oblique angle of 45° in relation to the tangent plane of the cornea at the point of penetration (Fig. 3, E and F).

The incision made with the keratome does not need to complete the section of the upper edge of the corneal flap, for in cases of shallow anterior chamber it is easy to injure the lens if the blade of the keratome is introduced too far into the anterior chamber. With the aid of the special scissors (Fig. 3, G), the section of the upper incision is finished as well as the other three edges of the corneal flap, maintaining the scissors at an angle of about 45° from the outside inward in order to obtain uniform bevelling, with the anterior surface of the flap larger than the posterior surface.

The graft to be transplanted is obtained, in the same fashion as has been described above, from an eye which has been enucleated while preparing the eye of the recipient. The enucleated eye is given to the surgon performing the transplantation as soon as the dissection of the leucoma has been completed. The eye is wrapped in gauze and held between the fingers (Fig. 3, L) without exerting either too much or too little pressure. If too much pressure is exerted by the fingers, the anterior segment of the eye is stretched and the resulting corneal segment excised fits loosely. If insufficient pressure is exerted the excised segment is too snug for the opening made in the recipient's eye.

The dissected graft is lifted with a spatula (Fig. 3, H, F) and, without being treated with any solution, is placed in the eye of the host in substitution of the resected portion of the leucoma. Once the transplant is in position, a gentle pressure is made with the spatula at the junction of the transplant and the cornea of the host (Fig. 3, I) in order that the epithelial surfaces of both may be on the same level. The conjunctival flaps are then carefully pulled over the graft and the sutures tied (Fig. 3, J and K). A 3 per cent solution of atrophine sulphate is instilled, and metaphen ointment placed in the conjunctival cul-de-sac. Binocular non-compressive dressing is applied.

Fig. 3, K, shows a cross-section of the eye when the operation is completed.

POST-OPERATIVE CARE

During the first six days after the operation, the patient must remain in bed as quietly as possible, with the exception of lifting the head and back if feeling uncomfortable. The night of the seventh day after the operation a dose of cascara is given to the patient, followed the next morning by a small dose of milk of magnesia and an oil enema, retained for one hour, which produces a soft evacuation without effort. The first dressing is made two days after the operation with the purpose, only, of inspecting the eyelids, but without examining the eye. Four days later, the second dressing is made and the eye carefully inspected. Care must be taken not to exert any pressure which might lead to the detachment of the transplant. Metaphen ointment is applied and a binocular dressing replaced.

Subsequent dressings are made every other day with the application of metaphen ointment. If the patient has useful vision in the unoperated eye, it can be uncovered around the tenth day after the operation. The post-operative course is different in each individual case, depending upon the condition of the eye. If the only pathology in the eye is the corneal leucoma, it is to be expected that by the sixth day after the operation, the conjunctival flaps will begin to separate. Two or three days later, the transplant may be uncovered. The conjunctival flaps will then have pulled away from the cornea. From eight days to three weeks after the operation, it is expected that the conjunctival sutures will fall out by themselves, but if some of them are still attached to the conjunctival flaps they can be removed and the eye uncovered.

In complicated eyes, such as those with heavy scarring of the conjunctiva, hypertension, aphakia with loss of vitreous during the operation, the post-operative course may be prolonged.

The patient is given a fluid diet the first two days, semi-fluid during the following four days, then gradually changed to normal diet.

REPORT OF CASES

CASE 1

Case 1: Mr. A. F., 51 years. Corneal opacity of the right eye as a sequela of corneal ulcer (Fig. 4), complicated by iritis and secondary glaucoma five years ago. Anterior chamber, pupil, and tension normal. Vision: hand motions at one foot. Left eye normal with vision 20/15. Blood grouping A (ii). Keratoplasty 8/24/33 without complications.

Donor C. K., 29 years, with a clinical diagnosis of sarcoma of the choroid in the macular region. Vision 20/40. Tension normal. Cornea at the time of the operation was perfect. Blood grouping O (i).

Post-operative course was uneventful. Transplant was entirely transparent at the first dressing six days after the operation. Three weeks after operation, vision 20/80, with pinhole 20/40. Transplant has remained unchanged ever since (Fig. 5). Vision at present 20/30—with pinhole.



Figure 4.—Case 1 Before Operation.



Figure 5.—Case 1 Ten Months After Operation.

CASE 2

Case 2: Mr. W. B., 24 years. First examined July 23, 1933. Right eye shows marked horizontal nystagmus and dense corneal leucoma, sequela of gonorrheal infection at birth (Fig. 6). Transillumination reveals the pupil to be small, irregular, slightly deviated upwards, and iris totally adherent to posterior surface of leucomatous cornea. Tension markedly increased to fingers. Vision light perception and projection.



Figure 6.—Case 2 Before Operation.

In December, 1933, the patient returned for a second examination, two operations having been performed on the right eye to liberate the cornea from the adherent iris. Transillumination showed that the upper temporal quadrant of the iris had been removed, leaving an eccentric area of cornea above and temporally free from synechia where a corneal transplant could be placed. Vision light perception and projection. Tension 40 mm. with Bailliarts tonometer. Blood grouping O (i). Keratoplasty performed 12/19/33. At the operation it was found that the lens was absent; the vitreous herniated through the corneal opening and would not allow a good fitting of the transplant. The so-called hyaloid membrane was purposely broken and a very small amount of vitreous removed with a swab until this fluid did not have further tendency to prolapse. The transplant was placed in position and the operation finished in the usual manner.



Figure 7.—Case 2 Five Months After Operation.

Donor H. M., 6 years (boy). Vision 3/200. Clinical findings suggested a tumor of the retina and enucleation was advised. Tension normal. Cornea was in a perfect state of preservation at the time of operation. Blood grouping A (ii). Microscopic diagnosis pseudo-tumor of the retina.

Post-operative course: uneventful. The transplant has remained transparent (Fig. 7). Vision fingers at 3 feet.

CASE 3

Case 3. Mr. R. F., 34 years. Patient states that four years ago his eyes, face and hands were severely burned by the explosion of a container in which several caustics were held. Examination of the right eye shows a very dense corneal leucoma, with vessels penetrating from the limbus radially towards the center of the scarred cornea (Fig. 8). The leucoma is so dense that there is very faint dis-



Figure 8.—Case 3 Before Operation.

tinction between the scarred cornea and the conjunctiva. The inferior cul-de-sac is normal. The superior fornix has been partially obliterated and there exists a central symblepharon. Posterior transillumination reveals an immobile, small, round pupil, centrally located. Anterior transillumination seems to indicate complete obliteration of the anterior chamber and therefore a large or total

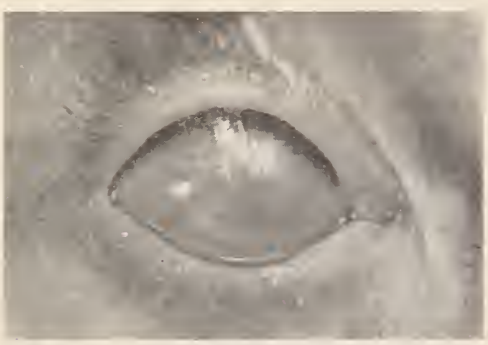


Figure 9.—Case 3 Seven Months After First Corneal Transplantation.

anterior synechia. Tension 23 mm. with Bailliarts tonometer. Vision good light perception and doubtful projection with the ophthalmoscope. With the slit-lamp beam, projection is fairly good in every direction excepting the nasal side. The upper lid of the left eye is totally adherent to the cornea. Tension 45 mm. with Bailliarts tonometer. Vision nil. Blood grouping A (ii). Keratoplasty 9/26/33 revealed that the cornea was at least twice the normal thickness. The iris was adherent to the cornea and lens, and the lens was opaque.

The iris was cut all around the corneal opening, and through the same opening an extracapsular cataract extraction was performed. The transplant was placed in position and the conjunctival flaps sutured in the usual manner.

Donor, Mrs. M. W., 58 years. Clinical and microscopic diagnosis of detachment of the retina and

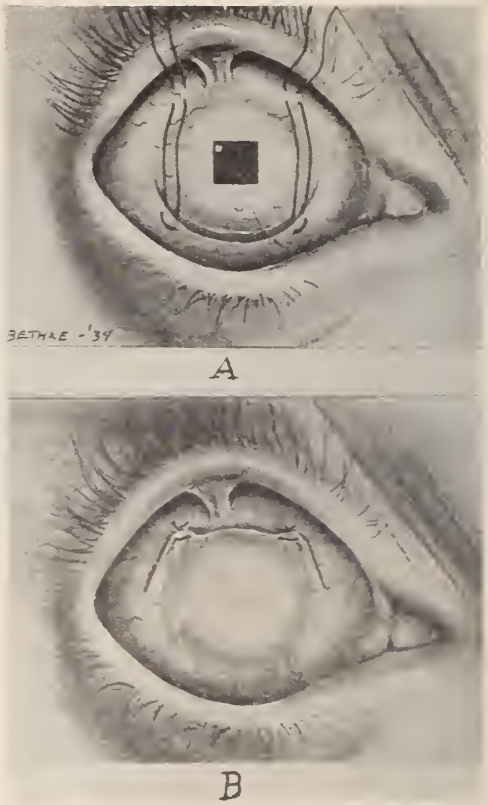


Figure 10, A and B.—Variation in Author's Technic Used in the Second Corneal Transplantation of Case 3.

pthisis bulbi. At the time of the operation the corneal flap was slightly edematous.

Post-operative course: healing took place with-

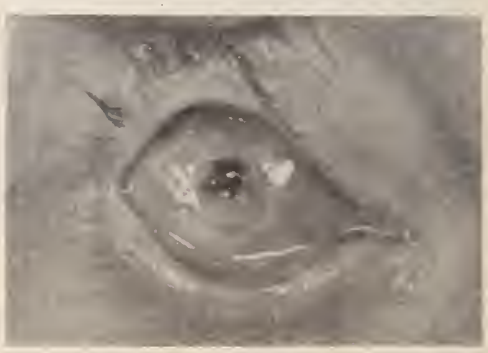


Figure 11.—Case 3 Two Months After Second Corneal Transplantation.

ous complications. During the first two weeks the transplant remained transparent, but edematous. Through the transplant, anterior chamber could be seen with cortical remnants of the lens and some

blood. Afterwards the transplant gradually became nebulous. 11/23/33, anterior chamber was opened at the limbus below, and the iris was found to be adherent to the temporal edge of the transplant. The iris was then freed and a large iridectomy performed below. Lens remnants came out and with them a drop of normal vitreous. Transplant afterwards became gradually opaque (Fig. 9). Vision: good perception and projection. The specific object of the second operation was to remove the lens remnants and the synechia, preparing the cornea for a second transplantation. 4/5/34, a second transplantation was performed, using only a lower conjunctival flap to cover the transplant (Fig. 10, A). The upper conjunctiva could not be dissected because of the heavy scarring and increased symblepharon subsequent to the first operation for corneal transplantation. During the operation the vitreous herniated through the corneal opening and a very small amount of this fluid was removed with a swab, until it did not have further tendency to prolapse. The transplant was then placed in position and covered with a lower conjunctival flap held in place by two mattress sutures (Fig. 10, B).

Post-operative course: The transplant was buried under the conjunctiva for about one month, and then the conjunctiva was dissected. The transplant was found to be rather transparent, and has remained unchanged ever since (Fig. 11). Vision at present: fingers at two feet.

CASE 4

Case 4: Mr. W. O'H., 67 years. Right eye lost by injury 35 years ago. Vision nil, presents some corneal opacities, but there is an area of cornea of about 4 mm. square, from which a transplant could be obtained.



Figure 12.—Case 4 Before Operation.

Left eye: Gradual failure of vision for the past 12 years. Before 1929 the following operations were performed:

1. Needling.
2. Needling followed by complications (?).
3. Optical iridectomy.
4. Unsuccessful corneal transplantation in 1929.

In 1930, the patient was admitted to Bellevue Hospital and the following operations performed in his left eye:

1. May, 1930, transplantation of conjunctiva .
2. June, 1930, corneal transplant, attempted.
3. May, 1931, cataract extraction.
4. June, 1931, paracentesis for secondary glaucoma.
5. August, 1931, discission.
6. November, 1932, optical irridectomy.



Figure 13.—Case 4 Three Months After Operation.

February 8, 1934, examination of O. S. revealed a complete, dense corneal leucoma and scars at the limbus, indicating several operations had been performed (Fig. 12). Transillumination showed the presence of an immobile portion of iris present from 2 to 7 o'clock temporally. Vision—light perception and projection. Tension normal. Keratoplasy, February 28, 1934, with loss of vitreous. Transplant obtained from the right eye of the patient. Transplant slightly nebulous when dissected.

Post-operative course uneventful. Transplant has remained fairly transparent (Fig. 13). Vision—fingers seen at three feet.

SUMMARY AND CONCLUSIONS

Homokeratoplasty and autokeratoplasty can successfully be accomplished when a suitable technique is followed. The number of patients operated upon is not sufficient to draw definite conclusions as yet, but it may be stated that when the method described in detail is used in eyes favorable to undergo such type of operation, a high percentage of success may be expected.

In those eyes in which the anterior segment is severely affected, the results cannot be expected to be so brilliant, but a definite improvement can be obtained, as shown in the cases here reported, which justifies the advisability of operation.

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DISCUSSION

Elbert S. Sherman, M.D., Newark: For over a hundred years restoration of vision to an eye made blind by opacities of the cornea has been a problem to which many ophthalmologists have devoted their best efforts.

Until comparatively recently all attempts, with two or three exceptions, to excise a section from an opaque cornea and substitute a graft from a clear cornea have resulted in little better than failures. If the implant healed, it usually became opaque in a short time. Other complications and sequelae such as iris prolapse, glaucoma, atrophy of the eyeball and infections were frequent and discouraging. During the past twenty years Elschnig and several others, using a modified von Hippel technique, have reported a large number of cases of keratoplasty, in many of which the results were very encouraging.

For a long time it has been known that the graft must be an autotransplant or a homotransplant. Keratoplasty with heterotransplants has been uniformly unsuccessful.

Many years before von Hippel devised his trephine, the importance of the exact correspondence in size and shape of the graft and the excised section was recognized. Dr. Castroviejo's twin-bladed knife meets this essential principle with exactitude and with a minimum of trauma. After several years of research and experimenting on animals' eyes, he has worked out a technique which gives a higher percentage of healed, transparent transplants than has been had by any other method. It is safer and does away with some of the technical difficulties of the older operations.

His method of excising the section of opaque cornea which makes it possible to operate with a dilated pupil, thus avoiding incarceration of the iris in the wound, is very important. In the trephine operation it is necessary to have a contracted pupil to avoid injuring the lens. His method of securing the transplant from displacement by bevelling the two edges and covering it with conjunctival flaps serves the double purpose of holding it in place and favoring its nutrition. These are some of the salient advantages of this new technique over older methods.

For his persistence and resourcefulness in working out this outstanding contribution in this difficult and discouraging branch of ophthalmic surgery, Dr. Castroviejo deserves much praise. I have seen some of the eyes on which he has operated. The results are convincing of the worth of his method. Its field of usefulness is, of course, limited. In most cases of superficial opacity of the cornea, the opacity, as a rule, is not so extensive but that an area of clear cornea remains, behind which the simpler and safer operation, iridectomy, can be done. Also, eyes which do not have a normal anterior chamber or a healthy Decemet's membrane are unfavorable for operation. However, there must be many eyes which have heretofore been considered hopelessly blind because of total or nearly total corneal opacities, to which some useful vision could be restored by this method of keratoplasty.

It would apparently be an advantage to complete the corneal incisions with a knife instead of scissors. I may have overlooked some technical reasons against this, but would it not be feasible to complete the three incisions with a thin single-bladed knife similar to the blades in the twin-knife? To protect the lens, a keratome slightly wider than the interval between the vertical incisions could be used and held in place behind the cornea while the incisions are completed, cutting down onto the keratome. The graft, cut in the same way, could be lifted out on the keratome and transferred directly to the defect. Incisions made in this manner would be cleaner, more exact, and less traumatizing than when made with scissors.

I want to thank Dr. Castroviejo for coming to us with this interesting and valuable paper.

OSTEITIS FIBROSA

By Charles O. Leff, M.D., Kenneth Blanchard, M.D., and
C. Maurice Peabody, D.D.S., South Orange, N. J.

Osteitis fibrosa, first so ably described by Von Recklinghausen as a clinical entity, has since accumulated a commendable literature and deserves consideration other than that accorded a rare disease.

The more recent works on this subject by Bloodgood, Geschickter and Copeland, Volkman, Morton, and Garland have greatly advanced the present-day knowledge of this disease, especially from the pathogenic and pathologic viewpoint.

In the authors' series, the above knowledge was supplemented and was employed as a basis for a better understanding of the clinical picture, having in view the possibility of evolving a therapeutic régime more rational and homogeneous than the heterogeneous therapeuses now in vogue as disclosed by a review of the literature on the subject.

PATHOGENESIS

The disease in counterdistinction to other osseous dystrophies, we believe, is characteristically confined to the first two decades of life. It is associated with the period of greatest bone growth. The pathological process is usually confined to the region of new bone formation. The most numerous sites of involvement are the metaphyseal portion and shafts of bones. The shafts of the bones involved, in the order of frequency, are the femur, especially the greater trochanter, humerus, tibia, fibula, radius, ulna and the clavicle. The epiphyses are not involved.

We believe that the disease originates as part of a generalized pathological picture induced by some extra-osseous non-fulminating pathological insult to the individual resulting in a disturbance in the calcium metabolism causing the common basic fundamental changes noted in pathologic conditions of bone superimposed upon bone in its growing state. There is no evidence of reaction or changes as are noted in inflammatory bone processes. There is present the characteristic defense reaction of bone and its component parts characterized by attempts at repair by vascularization, by proliferation of fibrous elements and healing by attempted new bone production in young active growing bones.

PATHOLOGY

Pathologically, there is a disturbance in the normal relationship between bony resorption and deposition. When the latter cannot balance the changes produced by the former, osteoporotic changes follow.

There are noted various phases of intensity of this dystrophy as the disease develops and progresses. These phases can be classified as follows:

1. Primary Diffuse Generalized Osteitis Fibrosa. The primary osteoporotic dystrophy or tendency, a primary molecular disturbance of the bone forming elements. Underlying bases for all secondary types.

2. Secondary Osteitis Fibrosa
   - A. Generalized Type
     1. Without bone cysts
     2. With bone cysts
   - B. Localized Type
     1. Diffuse involvement of a portion of the shaft of a single bone
     2. Circumscribed involvement of the shaft of a single bone.

The secondary types reveal advanced bone and marrow involvement, and are usually the ones seen by clinicians. There is healing reaction present but the necessary elements of the reaction and process are not vital enough to successfully repair the damage by replacement with bone forming elements. There may be generalized or localized areas of fibrous tissue. There may be cystic areas, single or multiple, with or without fluid or fibrous tissue. The periosteum does not react by new bone formation. The cortex is more or less present. Stress

or strain may be the cause of bending or fracture of the bone.

ETIOLOGICAL FACTORS

Careful familial and individual histories reveal two general classifications of conditions which may sufficiently influence the calcium metabolism to produce the necessary factors instrumental in bringing about a dystrophy such as osteitis fibrosa, directly or indirectly.

1. Pathological conditions affecting the mother and those relative to pregnancy.
   - A. Toxemias of pregnancy
   - B. Diseases of the uterus and fetus
   - C. Metabolic and deficiency diseases
   - D. Chronic diseases, concomitant with or ante-dating pregnancy, of the
     1. Cardio, renal, or hematic systems
     2. Digestive system
     3. Muscular, joint, and osseous system.
   - E. Acute infectious diseases accidental to pregnancy.
2. Pathologic conditions affecting the child during development and growth
   - A. Nutritional disturbances of infancy and childhood
   - B. Dietary imbalance with disproportion of the antirachitic factor
   - C. Metabolic dyscrasias, especially the parathyroids
   - D. Acute and chronic infectious diseases
   - E. Chronic diseases of the
     1. Digestive system
     2. Renal or hematic systems.

CLINICAL FORMS

An analysis, according to our pathological classification, of fifty-two cases of the primary type, and fifty-four cases of the secondary type of osteitis fibrosa, reveals two general clinical forms, the *asymptomatic* and the *symptomatic* form.

The *asymptomatic* form is the most difficult form to recognize. In this form there are no demonstrable clinical signs or symptoms present to indicate the pathological state of the patient. It is brought to the clinicians' attention in one of the following ways: as

1. A spontaneous fracture of a bone
2. A fracture incurred as a result of a direct or indirect injury
3. An induration and swelling, with or without pain, either caused by direct or indirect injury or associated without injury, to a pathologic bony member
4. An unsuspected finding revealed during a medical or dental x-ray examination
5. A suspected bowing or bending of the extremities.

Examination reveals no other deviations from the normal. The laboratory findings are essentially negative. There are no immediate chemical or microscopic changes of the blood. The blood calcium and phosphorus are within so-called normal limits. The urine also reveals no immediate chemical or microscopic changes. The excretion of chlorides, calcium, or phosphates is not increased. The x-ray, however, reveals the only identification of the pathological state.

The *symptomatic* form reveals certain deviations from the normal which when recognized may lead one to suspect an underlying osteitis fibrosa before the occurrence of such gross clinical pathological end-results as are observed in the asymptomatic form. These deviations may help in establishing the underlying cause after the occurrence of such gross pathological end-results.

The symptomatic form presents two types, the *hypertonic* type and the *hypotonic* type. Under certain conditions a case may present a transitional type and have some signs and symptoms of both.

HYPERTONIC TYPE

The *hypertonic* type may show one or more of some of the following changes in various degrees of intensity and various combinations:

Skin—Pallor of face and extremities; coldness of extremities. Tendency toward puffiness.

Appendages—Dental dystrophies characterized by fragility and enamel defects. Hair roughing, coarseness, falling, or thinning with disturbance in growth and pigmentation. Nail brittleness, ridging, flattening, or distortion.

Nervous System—Increased reaction to galvanism. Hyperexcitability of sensory and motor nerves. Tendency toward increased excitability of the autonomic nervous system with mild crises of sympatheticotonia and vagotonia. Tremors of the extremities. Sphincter disturbances.

Circulatory System—Vasomotor disturbances; hypertonia of peripheral circulation; angiospasm; edema of the neurotic type. Tendency toward becoming easily exhausted. Tendency toward variation in temperature especially toward the subnormal.

Digestive System—Alternating stages of increasd peristalsis, decreased emptying time, hypersecretion, localized spasms, or intestinal atony, dilatation, and constipation. Many are treated for various intestinal disturbances. Most are operated for chronic appendicitis. Few are relieved.

Special Senses—Hearing disturbances; usually diminished or distorted hearing. Visual sight impairments due to structural changes; tendency to cataract formation.

Laboratory findings reveal:

Blood—Decreased calcium. Range varying from 9 mg. to 7 mg. per 100 cc. Increased blood phosphorus. Moderate anemia.

Urine—Decreased calcium and phosphorus excretion.

Spinal Fluid—Calcium within normal limit.

X-ray—Reveals the presence of osteitis fibrosa. The secondary types predominating.

HYPOTONIC TYPE

The hypotonic type is more or less intimately associated with some parathyroid change. This may be due to a hyperfunction, a hyperplasia, or an adenoma of the glands. One or more glands may be involved. The hypotonic type may show one or more of the following changes in various degrees of intensity and various combinations:

Skin—Flabbiness, puffiness, tendency toward subcutaneous fluid increase. May be localized edematous areas.

Appendages—Dental dystrophies characterized by irregular patchy enamel formation, places of hardness and of softness. Nails reveal irregular formation with metastatic cornification. Hair changes are similar to the hair changes in the hypertonic type.

Nervous System—Muscular weakness, flaccidity, hypotonia. Pains in extremities. Repeated movements cause exhaustion or tiring easily; recuperation is prolonged. Attacks of pain and swelling. Decreased reaction to galvanism. Deep reflexes diminished. Decreased sensory and motor response. Muscles in advanced stages reveal a tendency toward stiffiness, wasting, fibrous or atrophic changes.

Digestive System—In early and moderate cases: nausea, vomiting, and constipation. Recurrent attacks of diffuse abdominal pains. Polydipsia. Advanced cases reveal marked atony, flaccidity, diminished peristalsis and secretions. The stomach and intestines finally lose muscular and mesentery tone to such an extent that they shift toward the dependent portion of whatever the adominal position may be.

Circulatory System—Tendency to myocardial degeneration. Hyperemia, hemorrhage, or thrombosis may occur of the lungs, gastro-intestinal tract, liver, heart or brain.

Renal System—Polyuria, insufficiency, impairment, or degenerative changes.

Metastatic calcification of circulatory system, kidneys, lungs, gastro-intestinal tract, thyroid, parathyroids, adrenals, spleen, skin, cartilage, and muscle. Calculi formation.

LABORATORY FINDINGS

Blood—Increased calcium, range from 12 to 22 mg. per 100 cc. Decreased phosphorus, range from 1 to 4 mg. per 100 cc. Blood clotting imperfect, friable, and poorly retracted. Moderate anemia. Clotting time decreased.

Urine—Increased calcium excretion, above 30 per cent, usually about 45 to 70 per cent. Increased phosphorus excretion. Increased chloride excretion. Increased water excretion. Casts and destruction of renal epithelium occasionally.

Spinal Fluid—Calcium within normal limits. One case had 4 mg. per 100 cc.

X-ray—Secondary types; especially the generalized type with or without cysts predominating. Fractures are common.

X-RAY

The x-ray is of prime importance as a laboratory agent in the diagnosis of osteitis fibrosa. With the proper use of the x-ray, an early diagnosis can be made. It is recommended that the most likely sites of predilection be x-rayed in every suspected case.



No. 1 No. 2

Figure 1.—Osteitis Fibrosa with Circumscribed Involvement of the Shaft of the Tibia before Treatment (No. 1) and Five Months After the Institution of Treatment (No. 2).

Our pathological classification was of inestimable value as a working basis. The primary diffuse generalized type, the secondary generalized type without bone cysts, and the localized diffuse involvement of a portion of the shaft of a single bone were especially looked for. The first of the three, because it is the earliest type and the most amenable to treatment; and the latter two, because they are more common and more involved and are easily overlooked.

The generalized type with bone cysts, and the circumscribed involvement of the shaft of a single bone are the most spectacular roentgenologically and have been the models most often demonstrated in works on osteitis fibrosa. These types are not easily overlooked. The generalized type with bone cysts should be especially x-rayed at the most common sites of predilection as the majority of these cases reveal more than one bone that is cystic.

The following pathological states may cause some difficulty in roentgen interpretation:

A. *Giant cell tumor.* Occurs in childhood and young adult life. It is of the destructive type, usually involving the epiphysis and the end of the shaft. The bone is widened at the site of the tumor which is expanding in character, usually single and usually trabeculated. The cortex of the bone is thinned but intact. The soft tissues are not invaded except when fracture occurs, but may under certain conditions involve ligamentous attachments. The most common sites of predilection are the lower end of the femur, upper end of the tibia, the spine, and the jaw.

B. *Enchondromata.* Common in childhood and young adult life. It is of the destructive type, usually developing near the ends of the shaft. It causes enlargements that are irregular with overlying tissue distortion. The cortex is usually thinned and the bony markings are replaced with a homogenous shadow or areas of rarefaction. Enchondromata are usually multiple. The most common sites of predilection are the hands, feet, and the long bones.

C. *Osteogenic sarcoma.* Early central sarcomas may cause confusion. However, the consensus of opinion is that they are rare in young people. In the early stages, the differential diagnosis between this condition and osteitis fibrosa is difficult especially before the cortex has been invaded. There are also certain types of osteogenic sarcoma which may show medullary involvement and contain cartilage or mucoid substance and may be classed as the chondromata or myxosarcomata which must be taken into consideration.

D. *Other lesions* which must be taken into consideration because they may cause confusion in roentgen differentiation are: Chronic fibrous osteomyelitis, chronic rarefied osteomyelitis, early chronic bone abscesses such as the Brodie type, early rarefying osteitis, rarefactions of disuse, certain types of syphilitic osteitis, and tuberculosis of the encysted type. The following rare lesion may sometimes have

to be considered: myxomas, blastomycosis, and parasitic bone cysts.

Whenever it is possible, roentgenograms of the mother and other children of the family should be taken. In our series this was not carried out at first because we did not fully recognize the importance of some of the pathological conditions affecting the mother, which can be seen roentgenologically, as one of the etiological factors in osteitis fibrosa. The majority of the etiological factors were not x-rayable. The routine roentgen examination of the mother and children in a family is a very expensive procedure. We, however, were able to study eighteen maternal cases roentgenologically. These cases do not represent an average cross-section of this study because the cases were selected. Only mothers of patients having the more severe forms of secondary osteitis fibrosa or themselves suspected clinically of having pathologically bone involvement were so studied. Our pathological incidence, therefore, we believe is higher than the average.

Of these cases, seven were negative for bony pathology; one case revealed a moderate form of osteomalacia; one case developed osteomalacia during the third pregnancy; one case had a healed tuberculosis of the right hip; one case had a moderate exostosis of the humerus of one arm and a moderate degree of myositis ossificans of the opposite elbow; two cases showed changes of hypertrophic pulmonary osteo-arthropathy; two cases had healed osteomyelitic processes; and three cases revealed moderate hyperthropic arthritis of the post infective type.

The same handicaps affecting the maternal study were encountered in the child study. Six cases were studied and these were selected because they were related to one who had a severe form of osteitis fibrosa or they themselves were suspected of some form of bone involvement.

CASE HISTORIES

Case 1. Mother had eclampsia twice, three children, roentgenologically negative; the oldest was negative, the second has had rickets, and the youngest showed a generalized osteitis fibrosa with cysts.

Case 2. The mother had a healed tuberculosis of the right hip, two children; the oldest had a generalized osteitis fibrosa, and the youngest had a circumscribed involvement of the shaft of the humerus.

Case 3. Mother operated for a toxic type of thyroid, roentgenologically negative, three children; the oldest had a generalized type of osteitis fibrosa with cysts involving the femur and humerus, the second had tetany, the youngest died of an unknown cause. Subsequent reëxamination of the roentgenograms revealed a generalized diffuse osteitis fibrosa.

Case 4. Mother was negative, two children; the oldest was negative, the youngest had multiple fractures through cystic areas in the tibia and humerus.

Case 5. Mother had cardio-renal impairment, roentgenologically negative for bone lesions, three children; the oldest was negative, the second had spasmophilia and rickets, the youngest had an alimentary intoxication and a diffuse involvement of the shaft of the right femur.

Case 6. Mother had mitral disease when fifteen years of age, subsequently infective arthritis, two children; both children had osteitis fibrosa with cysts, one involving both femurs and the other involving the left tibia.



No. 1 No. 2

Figure 2.—Osteitis Fibrosa of the Generalized Type with Multiple Cystic Involvements of the Femur before Treatment and Six Months After the Institution of Treatment

DIAGNOSIS

This study is an attempt to find some ways and means the use of which may serve as a preliminary groundwork, by further study, whereby osteitis fibrosa may be detected early and diagnosed. The detection of osteitis fibrosa before gross pathological derangements occur is what constitutes such a diagnosis.

This study has firmly convinced us that osteitis fibrosa is not a disease entity fundamentally. It is rather a sequela dystrophy, the groundwork for such a sequela having been laid in some previous existing altered develop-

ment, derangement of function, or disease. These conditions have caused an involvement of the calcium and phosphorus metabolism, especially the former, and are not solely confined to the osseous system.

A careful maternal and pre-natal history is essential as the maternal pathologic conditions relative to pregnancy are an important part of the etiological factors. Any disturbance of the calcium-phosphorus metabolism sufficient in degree to cause a deficiency in calcium before or during pregnancy may cause a disturbance in the calcium-phosphorus metabolism in the child.

Likewise, a careful history of the patient is essential as the pathologic conditions affecting the child during development and growth are an important part of the etiological factors. Any disturbance of the calcium-phosphorus metabolism sufficient in degree to cause a deficiency may under certain circumstances develop an osteitis fibrosa in the child.

Cardinal signs and symptoms are as yet unrecognizable in the asymptomatic form of osteitis fibrosa with our present state of knowledge of the subject. However, in the early symptomatic form, there are usually sufficient signs and symptoms present to arouse the suspicion of the clinician at least up to the point that some form of calcium dyscrasia is to be suspected. In the more advanced and moderate involvements such as the more distinct hypotonic and hypertonic types, the signs and symptoms are beyond the presumptive stage. It is in order to state here, that the dentist has the first opportunity in the great majority of cases of observing dental defects which when recognized fall into the category of the results of disturbed calcium-phosphorus metabolism. A closer study of these defects with the coöperation of the family physician would no doubt aid in the early detection and diagnosis of osteitis fibrosa.

Of the laboratory findings, the most important is that of the x-ray. Early roentgen findings of osteitis fibrosa are the most important, and to correctly interpret them requires a great deal of diagnostic acumen, a flexible standard technic, and a control of proportional and comparative factors for density, contrast, and detail study. Here we can also state that the dentist has usually the first opportunity in the majority of cases of observing jaw bone detail defects. The roentgenologist occasionally passes up the opportunity afforded him to study bone detail in association with roent-



No. 1 No. 2 No. 3 No. 4

Figure 3.—Osteitis Fibrosa of the Generalized Type with Bone Cysts Showing the Shaft of the Humerus before Treatment (No. 1), One Month After Institution of Treatment (No. 2), Three Months (No. 3), and Six Months (No. 4)

genograms taken for other suspected pathological processes.

As a laboratory finding, the blood calcium and the blood phosphorus are of secondary importance. In the asymptomatic form there is apparently no deviation of blood calcium and phosphorus from the normal. In the hypotonic type the total blood calcium is increased and the total blood phosphorus is decreased. On the other hand, in the hypertonic type, the total blood calcium is decreased and the total blood phosphorus is increased. The latter two conditions indicate and serve as a warning that there is some involvement of the blood calcium and phosphorus control mechanism or a disturbance between the supply and demand of calcium and phosphorus.

In the urine the same condition occurs. The asymptomatic form reveals no deviation in the excretion of calcium and phosphorus. The hypotonic type reveals an increase in the excretion of calcium and phosphorus, while the opposite is true in the hypertonic type.

TREATMENT

The prophylactic treatment of osteitis fibrosa can be practically carried out. It consists of two phases. The first phase lies in the recognition of pathological conditions affecting the mother and relative to pregnancy, and the pathological conditions affecting the child during development and growth; and treating these conditions according to the best known therapeutic methods of the day. The second phase lies in the recognition of the fact that such conditions or diseases that fall under the above classification of the etiological factors of osteitis fibrosa cause various disturbances of the calcium and phosphorus metabolism in the body and that the normal balance of this metabolism must be restored. The attempt to restore the calcium and phosphorus balance will be discussed in the direct treatment.

The direct treatment also consists of two phases. The first phase lies in recognizing and correcting any pathological condition or process of the patient which may directly or indirectly cause any of the various disturbances of the calcium and phosphorus metabolism of the body.

The second phase deals with the attempt to restore the calcium and phosphorus balance in the body. This is brought about by reversing the calcium and the phosphorus stream. To accomplish this various conditions favorable for the absorption, assimilation, and deposition of calcium and phosphorus must be created. This is brought about by medication and diet.

All patients are placed on a calcium positive diet. They are instructed to drink a minimum of one quart of milk, buttermilk, acidophilus, or lactic acid milk daily. This is intended to serve two preliminary purposes: one, for the calcium content contained therein; two, to help in creating favorable intestinal conditions for the absorption of calcium. In some cases where the absorption of calcium showed a reasonable amount of retardation, lactic, phosphoric or dilute hydrochloric acid was cautiously administered in small doses to increase the rate of absorption. Besides this, the following items are stressed as a necessary part of the daily diet: sweet cream, sour cream, various types of cheeses, all vegetables, especially cauliflower, dandelion, spinach, and celery; citrus fruits, eggs, and ice cream.

Medication is administered orally, intramuscularly or intravenously. In the early and moderate cases with a slight or moderate form of anemia but with good resistance to infection, we have found the following mixture very effective: three drams of tricalcium phosphate, two drams of lecithin to six ounces of cod-liver oil, or to four ounces of cod-liver oil fortified with carotene and vitamin D. This mixture is administered in one or two teaspoonful doses four times daily according to the severity of the case. Lecithin is used as a hematopoietic agent. In the moderate and advanced cases with poor resistance, 25 to 50 grains of tricalcium phosphate plus 25 to 50 grains of calcium lactate or gluconate are administered four times daily in one glass of milk. In addition five drops of caritol with vitamin D are administered on a piece of cube sugar with each of the above doses of calcium salt. Other forms of vitamin D and A compounds may be employed. The minimum requirement being 2000 units of vitamin D, and

2000 units of vitamin A. a, d. m. a. to each dose.

For prophylactic purposes and for the primary form of diffuse generalized osteitis fibrosa, the above dietary and medical régimé may be sufficient to obtain the optimum therapeutic results. However, in the secondary forms of osteitis fibrosa, the above régimé must be supplemented by intramuscular injections of calcium glucouate or intravenous injections of the gluconate or calcium chloride. The intramuscular or intravenous injections are especially desired in the clinically symptomatic forms to hasten relief from untoward symptoms; and in those extensive forms of the generalized type of osteitis fibrosa with or without bone cysts, and the localized diffuse or circumscribed involvements of bone in order to prevent such pathological complications as fractures or bending by hastening the process of bone regeneration.

The doses vary according to the severity of the symptoms or the amount and extent of bone involvement. In the moderately involved cases, one or two injections of 10 cc. of a 10 per cnt solution of calcium gluconate intramuscularly, weekly, may be sufficient. In the advanced cases, with extensive involvement, cysts, or fractures, as much as four intramuscular injections weekly may be given. The above doses are graduated into smaller doses or greater intervals according to the needs of the individual case.

The intramuscular injection is the medication of choice because of the ease of administration. Calcium chloride, 25 cc. of two per cent solution, was used where intravenous medication was feasible. It is especially effective in the symptomatic type. However, it can only be employed in young adults and is not without untoward local danger and general reactions.

In cases where fracture or bending has occurred, in addition to the customary orthopedic treatment, the above régimé was carried out, and the medication forced.

The supportive treatment consisted of treating symptoms as they presented themselves. In the symptomatic form, sedation was usually necessary at first. In some of the cases where the secondary anemia was pronounced, iron compounds were administered intramuscularly twice weekly. In refractory cases of kidney involvement hexylresorcinal two and one-half per cent solution in olive oil was administered orally in teaspoonful doses, two or three times daily, according to the age of the patient.

The above outlined treatment produced a marked improvement of symptoms in the most severe forms of the hypertonic and hypotonic types in two weeks, while the majority of cases showed relief from untoward symptoms from seven to ten days.

In the primary diffuse generalized type and in the early cases of secondary generalized type without cysts showed definite roentgen evidence of improvement. In the cystic and localized types, roentgen evidence of improvement was noticed in six to eight weeks. Occlusion of rarefied areas and cysts took place in from three to eight months in the mild cases, and up to three years in the most advanced cases. The healing of fractures was much improved on and the period of disability shortened.

The time element for improvement depended upon the severity and extent of the osteitis fibrosa, the extent of the involvement of the associate pathology and their response to treatment, the extent of calcium treatment, and the rapidity of absorption and deposition of calcium salts in the body. Roentgenograms taken at stated intervals helped to estimate the amount of improvement and determine the subsequent dosage and treatment.

When a satisfactory result has been obtained, the patient is placed on a maintenance dose of calcium. This dose depends upon the type of case and varies from .5 to 1.5 grams of total calcium daily, and this is continued for some time until there is satisfactory evidence that the scar bone that has initially formed is well organized.

Some time between symptomatic improvement and noted bone improvement, the blood calcium and phosphorus return to within normal levels. In one case, however, the blood calcium did not return to within normal limits but remained from 16 to 22 mgs. per 100 cc., and the improvement after three months of

intensive treatment was negligible. A therapeutic diagnosis of parathyroid adenoma was made. The patient was brought to operation and one parathyroid gland was found to be adenomatous and was removed. The patient made a subsequent uneventful recovery.

Little attention was paid to the calcium and phosphorus urinary excretion during active treatment. The daily variation was found to have a wide range and was no index to the response to treatment. The symptomatic cases having no kidney involvement showed a return to normal excretion when placed on the maintenance dose.

CONCLUSIONS

1. Osteitis fibrosa is not a fundamental disease entity but a sequela dystrophy, the groundwork for which has been laid before birth by pathologic conditions affecting the mother and relative to pregnancy, and after birth to pathologic conditions affecting the child during development and growth.

2. The various developments of the dystrophy can be classified, for pathological study, into a primary diffuse generalized type of osteitis fibrosa; and secondary osteitis fibrosa as a generalized type with or without cysts or the localized type with diffuse or circumscribed involvement of a single bone.

3. Clinically, osteitis fibrosa may be classified into the asymptomatic and symptomatic forms. The latter may be further subdivided into the hypertonic and hypotonic types.

4. The diagnosis of osteitis fibrosa is made upon a careful maternal, pre-natal, developmental, and growth pathological history of the patient; certain cardinal signs and symptoms; and laboratory findings of which the roentgen findings are of primary importance and the blood calcium and phosphorus levels are of secondary importance.

5. Any disturbance of the calcium-phosphorus metabolism sufficient in degree to cause a deficiency in calcium and phosphorus before or during pregnancy of the mother, and in the subsqent development and growth period of the child may give rise to such a condition as osteitis fibrosa under certain circumstances.

6. The treatment consists of restoring the calcium-phosphorus balance of the body by diet and calcium medication.

7. The results obtained warrant further metabolic study of osteitis fibrosa.

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ADEQUATE PAY FOR EFFICIENT MEDICAL CARE

By Nathan B. Van Etten, M.D., New York City

Summary and conclusions of an address before the Hudson County Medical Society, January 2, 1935.

How shall the sick be adequately served?

How shall the servants of the sick be adequately paid?

These are questions which should be debated in every county and state society before national commitments are made.

Before the advent of the professional philanthropist there was comparatively little complaint concerning the economics of medical care. The physician was more concerned with the welfare of his patient than with his own comfort or prosperity. All of modern medicine has been developed within the inclusive period of the last fifty years, and the progress of the science of medicine has been so absorbing that the art and application of medicine has lagged behind.

SUMMARY OF CONDITIONS

Few physicians have ever acquired wealth from the practice of medicine.

Many physicians are failing to make respectable livings.

Many physicians are excluded from the opportunity to practice their profession in tax-supported hospitals.

Fewer people are sick. Morbidity and mortality statistics are the lowest in history.

Fewer people are earning enough money to pay physicians.

More people than formerly visit all sorts of cheap clinics.

More counter-prescribing by pharmacists prevails.

More people eagerly accept and apply to themselves the medical advice of the radio broadcast.

More patent medicines are taken.

More physicians are being licensed than can be used by our citizens.

The community suffers from division of hospital support by too many hospitals or clinics too closely located.

The community has a poor return from its investment when hospital facilities are idle because of exclusion of practitioners who are qualified to use them.

CURE

All of these conditions can be cured by the concerted action of physicians, hospitals, welfare organizations, health departments, and an educated public.

These conditions cannot be cured by the imitation of any of the European systems of distributing medical care. They must be taken care of by ourselves within our own medical organizations:

By limiting the number of physicians newly licensed so that it may be possible for every competent physician to make a decent living.

By zoning cities and communities so that they may be served by small hospitals.

By opening all tax-supported hospitals to all physicians who live within the hospital zone.

By payment of physicians for their services to all tax-supported indigents within or without hospitals.

By exclusion from tax-supported hospitals of all non-emergent patients who are able to pay a private physician.

By development of the values of the personal and family physician as the basis of medical service.

By development of the full values of organized medicine in the enlistment of every physician into the ranks of the county medical societies.

By the maintenance of the highest quality of medical care.

His age-old experience and his education qualify the physician to meet a changing world and should qualify him for wise leadership of its evolution.

STATE SOCIETY ACTIVITIES

THE ANNUAL REPORTS

Following the precedent of last year, the Annual Reports of the Officers and Committees of The Medical Society of New Jersey will be printed in The Journal in advance of the meeting, and will be referred to *Reference committees* for analysis and suggestions for action on their recommendations. The following appeal has been sent to every officer and chairman from whom a report is expected:

"January 21, 1935.

"Dear Doctor ———:

"Subject: Annual Report.

"The annual report of each committee is to be sent to the Editor of The Journal of The Medical Society of New Jersey not later than March 1st, 1935. These reports must be printed in the April Journal.

"Preprints of these reports will be made as soon as they are received, and sent to the members of the various Reference Committees for study and suggestions, *prior* to the Annual Meeting in Atlantic City, April 30th, May 1st and 2nd, 1935.

"*Supplementary* reports may be presented at the Annual Meeting. These will also be given to the Reference Committee at that time for consideration and report as a part of the Annual Report of the Committee.

"Please endeavor to send *your* report in to the Editor of The Journal as much before March 1st as possible. This will lighten his load, and insure more careful study by the members of the Reference Committees.

"Sincerely yours,

"LeRoy A. Wilkes, M.D.,
"*Executive Secretary.*"

It may be expected that the reports will occupy the space of the department of "Original Articles", as they did in The Journal of May, 1934.

MATERNAL WELFARE COMMITTEE

The semi-annual meeting of the Maternal Welfare Committee of The Medical Society of New Jersey with the Maternal Welfare Commissions of the various County Societies was held at the Hotel Douglas, Newark, N. J., January 17, 1935. On account of the very bad weather many members were unable to attend and sent their regrets. Reports were received from nine counties and showed considerable work being done.

Dr. Clifford B. Lull, of Philadelphia, who spoke later at the Academy of Medicine, came in time for the afternoon conference, and the committee very much appreciated his presence.

Dr. Lancelot Ely, President, and Dr. J. B. Morrison, Secretary of the State Society, were present and gave us words of encouragement.

The committee adopted a set of standard rules for physicians and nurses to follow during delivery. (See next article.)

Bergen County. Dr. C. D. Cochran gave the report for the county. Members of the County Commission meet monthly to discuss ways and means of improving maternal welfare and to develop methods for uniformity in hospital records and statistics. They are improving their clinics, have better supervision and follow-up of prenatal care, and are having lectures and symposiums on obstetrics. They are encouraging consultations.

The County Society appointed Dr. Wilson, a member of the Commission, to investigate each and every maternal death. No cesarians have been done in any of the hospitals without a consultation with one of the attending staff. No reports have been received from Board of Health authorities.

Discussion was held as to how to get reports on outside maternity deaths. This will be taken up by Dr. Bingham.

In the last year the Maternal Welfare Commission gave a post-graduate course in obstetrics, with demonstrations and a good attendance at the lectures. Dr. Wilson said Dr. Richardson gave a particularly good demonstration.

Burlington County. A report was given by Dr. Curtis on local statistics.

Camden County. Dr. Davis being unable to attend, reported by letter.

Cumberland County. Dr. Mary Bacon being unable to come on account of the weather, reported statistics by telegram.

Essex County. Dr. Mount spoke on the recommendation made that maternity cases needing operative interference have consultation

with a recognized obstetrician or competent physician.

Monmouth County. Dr. MacKenzie reported that the commission is actively working for better obstetrics. A recommendation was made to ask the Department of Institutions and Agencies that applications for the establishment of Maternity Homes be referred to the Medical Society in the county in which the home is to be situated. This was seconded and passed. It was decided that Commissioner Ellis be approached with this recommendation. Dr. Ely, President of the State Medical Society, stated that Dr. Wilkes and himself were having a meeting with Commissioner Ellis on Tuesday, January 22nd, and would present this matter if a letter was written to them. It was suggested that Dr. Carl Ill, Secretary, write a letter to Dr. Wilkes in Trenton.

Dr. Bingham then appointed a committee of three, Dr. Carl Ill, Dr. Wilson and Dr. MacKenzie, to draw up rules and requirements for these Maternity Homes. These rules are to do only with the medical and surgical care of the patients; and not anything to do with plumbing, fire hazards, etc. Monmouth County Medical Society inserted an article in its bulletin giving notice of obstetrical meetings and invited all physicians to attend them.

Morris County. Dr. Frost reported the problem of getting statistics. Cesarians must have consultations.

Somerset County. Dr. Ely reported that a great deal of the work is being done by midwives, and the patients are sent into the hospital when the midwife is in difficulty. He feels everything is progressing nicely.

Union County. Dr. Bunting reported on statistics and told about some of their work.

Dr. Clifford Lull, of Philadelphia, gave a short talk on the work being done in New Jersey. He said he felt the commissions were doing pioneer work. He feels that the work is being recognized and that the commissions are functioning at least as well as any other in the country.

Dr. Morrison, Secretary of the State Society, said he believes that the committee is doing good work. He hopes that members of the County Commissions will all keep up their good work and keep the County Societies going well.

Dr. Ely read a letter from Dr. Wilkes about birth certificates to be given mothers; on the back of which is time for vaccination, etc., to be done, and a place to check when done. These are free and can be had by writing to Dr. Wilkes in Trenton, N. J.

Dr. Pudney gave a short talk on developing internes' obstetric consciences.

The meeting adjourned at 7 p. m. and was followed by dinner; and then by a meeting at the Academy of Medicine where Dr. Lull gave an interesting talk on "The Problem of Improving the Present Maternal Mortality Statistics", which was followed by a discussion.

Carl H. Ill, M.D., *Secretary.*

OBSTETRIC RULES

The following rules for the management of obstetric cases in hospitals were adopted by the Committee on Maternal Welfare at its meeting on January 17, 1935:

1. Gloves must be worn for all examinations and deliveries; hands must be scrubbed for five minutes before putting on gloves.
2. Do as few vaginal or rectal examinations as possible.
3. Except in post partum emergency, the doctor must be present when pituitrin is given. If given ante partum, the dose must not exceed five minims, and patient must be on the table ready to be delivered. Reasons for giving pituitrin must be recorded.
4. The obstetrician, aneathetist, and nurses must wear masks during examinations and delivery.
5. All cases of infection shall be transferred from the Maternity Department.
6. No douches or intravaginal treatments should be given in the Maternity Section.
7. All normal babies are to be put on the regular feeding routine.
8. All circumcisions must be done with strict surgical asepsis. Hands must be washed the same as for any other surgical procedure.
9. Consultation with a competent consultant is required in all of the following cases:
   a. All prolonged labors (24 hours).
   b. Cases requiring cesarean sections.
   c. Breech presentations (unless very premature).
   d. Difficult forceps cases or versions.
   e. Occiput posterior presentations requiring forceps or version.
   f. Other complicated cases:
      Eclampsia.
      Placenta previa, etc.

Recommended by the Maternal Welfare Committee of the Medical Society of New Jersey,

A. W. Bingham, *Chairman,*
144 Harrison Street, East Orange.

PROGRESS IN THE PUBLIC HEALTH HOUR

The following letter has been received from Dr. Stanley Nichols:

January 26, 1935.

Fellow-Members of The Medical Society of New Jersey:

Our letter to our members published in the January Journal (p. 34) emphasized the importance of each physician taking prompt steps to get the children in his practice immunized against diphtheria and smallpox. May I again urge that each of you make a definite list of the babies and children under your professional care between the ages of six months and six to ten years, and write each of them a letter asking them to come to your office for diphtheria immunization or vaccination with such explanatory notes on our State Medical Society plan as you see fit to add.

Essex, Bergen and Morris Counties, I believe, have prepared form letters along this line for their members, and other counties are planning to follow suit. However, a personal letter or telephone call from an individual physician to his patients will be even more effective.

Our State Committee has joined with the State Department of Health in preparing a suggested form letter for state-wide use, and we will make it available to every member of the State Society as soon as possible. We are anxious that each member proceed at once individually to immunize the children in his practice without delay in order to show our good faith and our coöperation with the health agencies of the State, and to roll up a large monthly total for each county.

You will see by the County Record for December that several counties have done extremely well. If your County is not among these, will you contact the Public Health Committee of your County Medical Society and see what you can do to help our health project function for the recovery of the medical practice of preventive medicine in the doctor's own office?

Fraternally yours,

STANLEY NICHOLS, M.D.,
Chairman, Public Health Committee,
The Medical Society of New Jersey.

The following statistical report shows the progress in the activities of "the Public Health Hour" during the month of December, 1934:

REPORTED IMMUNIZATIONS AND VACCINATIONS WITH FREE STATE BIOLOGICALS BY COUNTIES, FROM DECEMBER 1ST TO 31ST, 1934

County	Toxoid Immunization	Smallpox Vaccination
Atlantic	5	12
Bergen	413	106
Burlington	1	
Camden	169	106
Cape May	1	79
Cumberland	9	3
Essex	249	255
Gloucester	60	37
Hunterdon	9	17
Mercer	10	
Middlesex	51	112
Monmouth	210	1
Morris	5	36
Ocean	2	2
Passaic	105	35
Salem	3	13
Somerset	344	29
Sussex		
Union	8	12
Warren	1	1
Total	1655	856
Reported prior to Dec 1st	3352	1569
Total to Dec. 31st	5007	2425

PHYSICIANS' LIEN LAW

A harmonious conference of parties interested in the administration of the Physicians' Lien Law was held on January 18, 1935, in the State House in Trenton. Representatives of The Medical Society of New Jersey, the Bar Association, and the Insurance Carriers discussed the law and the features to which objections were made. None of the points of difference were insuperable, and there is every prospect that harmonious agreements will be reached in the near future.

The opposition to the Physicians' Lien Law was directed principally against its constitutionality. While the fee schedule has been adopted in three counties, a writ of certiorari has been issued in other counties, thereby blocking the hearings during the whole slow process of the court action. It was therefore thought best to attempt to amend the present law so as to eliminate the features to which objection was made. Such a law was introduced in the Senate (S. 134) on January 28 by Senator Hendrickson of Gloucester County, and was referred to the Judiciary Committee composed of Senator Barbour, Chairman, and

Senators Powell, Leap, Durand, and Stout.

A feature of the new Bill is that it impounds 25 per cent of the insurance reward and holds it to be paid to the doctor. The effect of the Bill will probably be to eliminate the fee schedule. It was on account of the fee schedule that the lawyers and the insurance companies brought up the question of the constitutionality, alleging that it was class legislation since it favored the medical group.

It is probable that new legislation favorable to the doctors may be secured promptly.

SCIENTIFIC EXHIBITS

Plans for the *Scientific Exhibit* at the Annual Meeting are progressing satisfactorily under the leadership of Dr. John W. Gray, Newark, chairman of the committee. An outline of the plans was printed on page 43 of the January Journal.

Many graphic representations of original work and research have been made in the hospitals and laboratories of New Jersey and will be shown at the exhibit, some of which will be shown at the meeting of the American Medical Association in Atlantic City as they were in Cleveland last year. The educational influence of the exhibits will be of great value.

The x-ray methods of diagnosis have been developed in recent years to such an extent that the radiologist is an essential consultant in every branch of medicine and surgery. Every physician will be enlightened and inspired by a study of the Scientific Exhibits. Special plans will be made for demonstrations and lectures by the exhibitors.

ART AND HOBBY EXHIBIT

The Committee on the Art and Hobby Exhibit at the Annual Meeting of the State Society met with representatives of the Woman's Auxiliary in the Executive Offices in Trenton on the afternoon of Tuesday, January 29, 1935. It was the opinion of the committee that the former exhibitions which have been held have aroused interest and should be continued and broadened in scope.

It was planned to secure an exhibit room that will be easy of access and to make it a center of sociability, whose practice is itself an art. Easy chairs will be provided and tea will be served by the members of the Auxiliary.

The committee solicits exhibits of works of art and collections of objects of artistic or historic value. Provision will be made for hanging pictures and photographs; and glass cases will be provided for the display of valuable small objects, such as collection of jewelry and postage stamps.

The following classification of articles for the exhibit will assist intending exhibitors to judge the desirability of entering their objects:

1. ART—Painting, sculpture, modeling, etching, engraving, drawing, needle-work, knitting, plastics, carvings, inlay work.

2. PHOTOGRAPHY—Still life, color, special processes, and movies in 35 m.m., 16 m.m. and 8 m.m. film.

3. HOBBIES—Collections, trophies, relics.

4. MEDICAL—Instruments, saddlebags, account books, photographs, textbooks, and anything else illustrating medical history.

5. SCHOOL WORK—Collections of flowers and botanical specimens, and drawings and posters of special merit, and models exhibited in schools.

The coöperation of the Woman's Auxiliary will insure the success of the Exhibit. No entrance fee will be charged, and no prizes will be offered. The satisfaction of contributing to the pleasure and enlightenment of the visitors will be the reward of the exhibitors.

All members of the society and of the Woman's Auxiliary, and all members of their families are invited to participate. Applications for space should be made to Mrs. H. D. Corbusier, 612 Park Avenue, Plainfield, N. J.

THE COMMERCIAL EXHIBIT

Plans for the Commercial Exhibit at the Annual Meeting are progressing rapidly. Abundant space will be provided; and its location will insure ease of access and will also prevent its noise reaching the assembly rooms.

Preparations for the exhibit itself will be in charge of one who has had wide experience in medical advertising and in making contacts with dealers in medical wares. The exhibit will have an educational as well as economic value.

PROGRESS ON THE NEW JERSEY FORMULARY

NEW JERSEY FORMULARY

SECOND INSTALLMENT

These formulas are issued with the approval of the Committee on Medical Practice of the Medical Society of New Jersey, and the Committee on Professional Relations of the New Jersey Pharmaceutical Association acting as a Joint Committee on New Jersey Formulary.

Formulas No. 1 to No. 5 inclusive were published in the Journal of the Medical Society of New Jersey for January 1935, page 42. Formulas Nos. 6 to 11 are published below:

Formula No. 6

LATIN TITLE

Elixir Amidopyrinae, N. J. F.

ENGLISH TITLE

Elixir Amidopyrine, N. J. F.

ABBREVIATION

Elix. Amidopyrin., N. J. F.

WORKING FORMULA

Amidopyrine	43.50 Gms.
Saccharine, Soluble	3.25 Gms.
Tr. Cardamom Compound	62.50 c.c.
Tr. Vanilla	3.00 c.c.
Alcohol	200.00 c.c.
Glycerin	500.00 c.c.
Distilled Water, sufficient quantity to make	1000.00 c.c.

Mix the Tr. Cardamom Compound, Tr. Vanilla, Alcohol, Glycerin and about 200 c.c. Distilled Water, and in the mixture dissolve the Saccharine and the Amidopyrine. Distilled Water to make to 1000 c.c. Filter if necessary.

Average Dose: One Teaspoonful. One average dose contains about 0.16 Gm. or 2½ grains of Amidopyrine.

Therapeutic Action: Antipyretic, analgesic.

Formula No. 7

LATIN TITLE

Pulvis Alkalinus Effervescens, N. J. F.

ENGLISH TITLE

Alkaline Effervescent Powder, N. J. F.

ABBREVIATION

Pulv. Alkal. Effervesc., N. J. F.

WORKING FORMULA

Sodium Chloride	2.00 Gms.
Magnesium Sulphate, Anhydrous	4.00 Gms.
Sodium Phosphate, Exsiccated	4.00 Gms.
Calcium Lactate	4.00 Gms.
Citric Acid, Anhydrous	20.00 Gms.
Potassium Bitartrate	26.00 Gms.
Sodium Bicarbonate	40.00 Gms.

Mix and sift twice through No. 60 Sieve. Preserve in well-stoppered bottles.

Average Dose: One level Teaspoonful. One average dose contains about 4 Gms. or 60 grains of the mixed powders.

Therapeutic Action: Antacid, Alkalizer.

Formula No. 8

LATIN TITLE

Pulvis Bismuthi Subnitratis Compositus, N. J. F.

ENGLISH TITLE

Compound Powder of Bismuth Subnitrate, N. J. F.

ABBREVIATION

Pulv. Bis. Subnitrat. Co., N. J. F.

WORKING FORMULA

Oil Peppermint	0.5 Gms.
Phenolphthalein	0.3 Gms.
Papain	4.0 Gms.
Diastase of Malt	10.0 Gms.
Bismuth Subnitrate	20.0 Gms.
Sodium Bicarbonate	35.0 Gms.
Magnesium Carbonate, Light	30.2 Gms.

Triturate the Phenolphthalein with the Sodium Bicarbonate and moisten with water, continuing trituration till pink color develops, then mix with other ingredients and sift twice through No. 60 sieve.

Average Dose: One level Teaspoonful. One average dose contains about 4 Gms. or 60 grains of the mixed powders.

Therapeutic Action: Antacid.

Formula No. 9

LATIN TITLE

Pulvis Bismuthi Subnitratis Compositus Cum Carbone Ligni, N. J. F.

ENGLISH TITLE

Compound Powder of Bismuth Subnitrate with Wood Charcoal, N. J. F.

ABBREVIATION

Pulv. Bis. Subnit. Cum Carb. Lig., N. J. F.

WORKING FORMULA

Oil Peppermint	0.50 Gms.
Wood Charcoal	2.00 Gms.
Papain	4.00 Gms.
Diastase of Malt	10.00 Gms.
Bismuth Subnitrate	20.00 Gms.
Sodium Bicarbonate	32.00 Gms.
Magnesium Carbonate, Light	31.50 Gms.

Mix and sift twice through No. 60 Sieve.

Average Dose: One level Teaspoonful. One

average dose contans about 4 Gms. or 60 grains of the mixed powders.

Therapentic Action: Antacid, Carminative.

Formula No. 10

LATIN TITLE

Liquor Ephedrinae Sulphatis, N. J. F.

ENGLISH TITLE

Solution Ephedrine Sulphate, N. J. F.

ABBREVIATION

Liq. Ephedrin. Sulph., N. J. F.

WORKING FORMULA

Ephedrine Sulphate	30.00 Gms.
Chlorbutanol	5.00 Gms.
Physiological Salt Solution, a sufficient quantity to make...	1000.00 c.c.

Triturate the Chlorbutanol with a small quantity of the Physiological Salt Solution till finely divided, then add to balance of the solution in which the Ephedrine Sulphate has previously been dissolved. Filter if necessary.

A 3 per cent solution of Ephedrine Sulphate for application to the nasal mucosa.

Formula No. 11

LATIN TITLE

Liquor Ephedrinae Et Epinephrinae, N.J.F.

ENGLISH TITLE

Solution Ephedrine and Epinephrine, N. J. F.

ABBREVIATION

Liq. Ephedrin. Et Epineph., N. J. F.

WORKING FORMULA

Ephedrine Hydrochloride	20.0 Gms.
Solution Epinephrine Hydrochloride	100.0 c.c.
Chlorbutanol	5.0 Gms.
Physiological Salt Solution, a sufficient quantity to make...	1000.00 c.c.

Triturate the Chlorbutanol with a small quantity of the Physiological Salt Solution till finely divided, then add to balance of the solution to which the Ephedrine and the Epinephrine have been added. Filter if necessary.

This preparation should not be dispensed unless recently prepared. It should be dispensed in amber-colored bottles.

A solution of Ephedrine with Epinephrine for application to mucous membranes combining the immediate action of Epinephrine with the slower and more lasting effect of Ephedrine.

Joint Committee on New Jersey Formulary representing the Medical Society of New Jersey and the New Jersey Pharmaceutical Association:

William R. Richart, Ph.G., *Chairman*
E. LeRoy Wood, M.D., *Vice-Chairman*
George C. Schicks, Ph.G., *Secretary-Treas.*
Robert P. Fischelis, Pharm.D., *Editor*

Thomas K. Lewis, M.D.
H. B. Wilson, M.D.
A. Anderson Lawton, M.D.
Chester I. Ulmer, M.D.
George M. Beringer
Jacob Feinberg
Everett J. Gorman
John H. Hoagland
Joseph Kaden
Kennetii Weeks

On Wednesday, January 16th, 1935, the Committee on Medical Practice of the Medical Society of New Jersey met with the Committee on Professional Relations of the New Jersey Pharmaceutical Association, at the New Jersey College of Pharmacy in Newark, for the purpose of organizing a *Joint Committee on Professional Relations* which is to sponsor the *New Jersey Formulary* referred to in an article on page 41 of the January 1935 issue of the Journal of the Medical Society of New Jersey. The committee organized by electing William R. Richart, Ph.G., Chairman; Dr. E. LeRoy Wood, Vice-Chairman; Professor George C. Schicks, Secretary-Treasurer, and Robert P. Fischelis, Pharm.D., Editor of the Formulary.

The Committee discussed ways and means of preparing and publishing formulas to be used by physicians in prescribing for their patients.

Every effort will be made to devise practicable palatable formulas of recognized drugs, and to submit them to the professions through their respective journals and possibly also in looseleaf form for permanent filing.

Physicians are urged to prescribe the mixtures listed in the formulary in preference to other ready-made preparations. The doctor benefits by the experience of the pharmaceutical leaders in making products both potent and palatable. If the physician, for example, wishes to prescribe *phenobarbital*, he writes "Elix. Phenobarb. N. J. F., ounces iv".

The pharmacist benefits by making his own products.

The patient benefits by the lower cost of the products as compared with similar ones dispensed under trade names.

The advantage of the New Jersey Formu-

lary lies in the fact that a definite standard of strength is worked out for each combination; and by specifying "*N. J. F.*" after the title of the formula, the physician will be able to obtain for his patients a product of standard strength, taste and quality, even though the combination of drugs has not yet reached the step of being included in the United States Pharmacopoeia, or the National Formulary.

The attempt to devise a New Jersey Formulary is in the interest of economy, uniformity, and excellence of product.

Physicians should consult page 42 of the January Journal of the Medical Society of New Jersey for formulas published under the following titles:

Elixir Phenobarbital
Syrup of Potassium Guaiacol Sulphonate
Powder of Bismuth Sub Carbonate Compound
Ephedrine Inhalant Plain
Compound Ephedrine Inhalant

A second installment of formulas appears in this issue on page 103. All of these formulas have the approval of the *Joint Committee on Professional Relations.*

OBLIGATION TO GIVE EXPERT TESTIMONY

A court decision in New Jersey makes a clear distinction between two kinds of testimony which a physician may give in court.

1. His *knowledge* of actual facts disclosed by his observation is public property and is available to a litigant for the same fee that is paid to any witness according to law.

2. His *professional opinion* is his own property which he may refuse to give unless he is paid for it.

This distinction is the basis of a decision by the Court of Errors and Appeals of New Jersey—Stanton v. Rushmore (N. J.), 109 A. 721—which is reported in the Journal of the A. M. A., August 18, 1934, page 519, as follows:

"The plaintiff, a physician, had professionally observed the condition of the defendant's wife, but whether with a view to treatment or with a view to giving evidence the reported decision does not make clear. Subsequently the defendant desired the plaintiff's evidence in a suit to which the defendant and his wife were parties, as to blows or bruises on the wife's body or anything in her condition that might lead the plaintiff to believe that she had been subjected to violence or physical mistreatment.

"The plaintiff expressed his unwillingness to testify and a subpoena was served on him. After the service of the subpoena the defendant promised the physician the amount which he would receive for a gall-bladder or appendicitis operation.

"The plaintiff then attended the trial, gave expert testimony and sent the defendant his bill. When the defendant refused to pay, the plaintiff brought action against him. Judgment was given for the plaintiff and affirmed by the Supreme Court The defendant appealed to the Court of Errors and Appeals of New Jersey.

"It is quite obvious, said the Court of Errors and Appeals, that the plaintiff testified as an expert. He not only stated the facts observed by him, but also expressed his professional judgment as to the condition he found and its cause. The question was squarely presented, therefore, whether a contract such as the plaintiff made was void as against public policy.

"It is quite clear, said the court, that all *knowledge* which a witness has of the actual *facts* of litigation, whether the witness be a professional man or a layman, is available, and that a witness is amenable to subpoena and compellable to give evidence of such facts.

"But the *experience, training and skill* of a professional man, acquired by years of study and practice in a given profession or calling, are not the property of the litigants. They belong to the professional man in his chosen occupation. Neither justice nor public policy, in the opinion of the court, forbids that the expert shall retain such knowledge and skill free from disclosure otherwise than by his *voluntary* act. This is true whether disclosure be sought for compensation for the exercise of his skill, or in the expression of his professional judgment privately, or as a witness in a court of justice. The right to compensation for services so rendered, the court thought, was generally recognized by the bar of New Jersey and compensation paid accordingly. The testimony of experts often involves long and tedious preparation for testifying, as well as the giving of results of training and experience to the appointed judicial investigators. It would be unjust and without legal justification to withhold payment therefor.

"Our conclusion", said the Court of Errors and Appeals, "is that an expert witness cannot as such be compelled to give testimony in response to subpoena; and, if such expert testimony is called for and given, it is the right of such person to contract for and receive proper and adequate compensation therefor."

REGIONAL CONFERENCE OF STATE SOCIETIES

A conference of representatives of the Medical Societies of eight East Central states was held on Sunday, January 27th, 1934, in Atlantic City, for the purpose of discussing national medical legislation. Dr. Frederic E. Elliott, of Brooklyn, Chairman of the Committee on Medical Economics of the Medical Society of the State of New York, presided. About twenty-five representatives were present. Those from New Jersey were: Dr. T. K. Lewis, Camden, Chairman of the State Committee on Medical Practice; Dr. E. W. Sprague, ex-President of the Essex County Medical Society; and Dr. LeRoy A. Wilkes, Executive Secretary of the State Society.

The attitude of the American Medical Association toward the project of Social and Economic Security that was outlined by the Federal Administration, was described by Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A. M. A. (See this Journal, November 1934, page 651). The special topic under discussion was the Bill introduced in the U. S. Senate (S. 1130), embodying the Administration's plans for old age security, unemployment, and dependency, but omitting sickness insurance. (See an analysis of this Bill on page 106 of this Journal.)

The Conference made definite suggestions along four lines:

1. That the Conference be organized on a permanent basis, with provision for holding regular meetings, and taking formal action representing the attitudes of the participating State Societies.

2. That the Conference formulate a definite program of medical service, adapted to present conditions.

3. That plans for carrying out the program be developed.

4. That a report of the discussions and proceedings be sent to each participating State Society.

The Conference has great possibilities as a district forum of the State Societies of the East Central States, affording opportunities for education and for the discussion of projects in which the entire medical profession is interested.

THE WAGNER BILL—SOCIAL INSURANCE

An abstract of S. 1130, introduced in the U. S. Senate by Senator Wagner, New York, to alleviate the hazards of old age, unemployment, illness, and dependency, to establish a Social Insurance Board in the Department of Labor, to raise revenue, and for other purposes.

This abstract was prepared under the auspices of the American Medical Association

TITLE I. OLD AGE ASSISTANCE

For the fiscal year ending June 30, 1936, there is appropriated $50,000,000, and for each fiscal year thereafter, $125,000,000, 99½ per centum of which is to be allotted to the several states to provide financial assistance "assuring a reasonable subsistence comparable with decency and health to persons not less than sixty-five years of age who, at the time of receiving such financial assistance, are not inmates of public or other charitable institutions." State plans must be approved by the Federal Emergency Relief Administration. The amount that is to be allotted to each State is dependent on the sum made available for similar purposes by the State and its political subdivisions.

TITLE II. AID TO DEPENDENT CHILDREN

For the fiscal year ending June 30, 1936, and for each fiscal year thereafter there is appropriated $25,000,000, nor more than 99½ per centum of which is to be apportioned among the several States to provide aid to children under the "age of sixteen in their own homes, in which there is no adult person, other than one needed to care for the child or children, who is able to work and provide the family with a reasonble subsistence compatible with decency and health." State plans must be accepted by the Federal Emergency Relief Administration. The federal allotment to each State is to be one-third of the amount made available by the State and its political subdivisions for similar purposes.

TITLE III. EARNINGS AND EMPLOYMENT TAXES

Beginning January 1, 1937, an earnings tax is to be imposed on every employee, except on a non-manual worker whose monthly salary is more than $250.

Likewise, an employment excise tax is to be imposed on every employer, at a rate of one-half of one per centum of the pay roll of such employer as of January 1, 1937, and increasing until the rate reaches two and one-

half per centum of the pay roll as of January 1, 1957.

The taxes so collected are to form a part of an old age fund.

TITLE IV. SOCIAL INSURANCE BOARD

In the Department of Labor, there is established a Social Insurance Board, composed of three members appointed by the President.

The Board, with the approval of the Secretary of Labor, may appoint and fix the compensation of such officers, attorneys, and experts as may be necessary to carry out its functions, without regard to the civil service laws and the Classification Act of 1923.

The duties of the Social Insurance Board are to be, in part:

a. To study and make recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old age insurance, unemployment compensation, accident compensation, health insurance and related subjects;

b. To supervise and direct the payment of old age annuities under a national contributory old-age insurance system; and

c. To assist the states in the administration of unemployment compensation laws.

For the fiscal year ending June 30, 1936, there is appropriated $5,000,000, and for each fiscal year thereafter $50,000,000, 98 per centum of which is to be apportioned by the Social Insurance Board to the several States which have certain types of unemployment compensation laws, the apportionment to be on the basis of need for financial assistance in the proper administration of such laws.

Old Age Annuities.—Beginning January 1, 1942, the bill provides for the paying of old age annuities to persons not less than sixty-five years of age who qualify under the bill. The amount to be paid each annuitant will be an amount equal to a percentage of his average monthly wage.

TITLE V. ANNUITY CERTIFICATES

The Social Insurance Board is authorized to borrow from time to time on the credit of the United States, for the purpose of increasing the old age fund, such sums as in its judgment may be desirable, and to issue therefor, at such prices and upon such terms and conditions as it may determine annuity certificates.

TITLE VI. UNEMPLOYMENT FUND

This title proposes to establish an unemployment fund and to collect annually from every employer of at least four persons an excise tax, measured by an amount equal to three per centum of the employer's pay roll. An employer may credit against this tax, up to 90 per centum of the tax, the amount of his contributions to any unemployment fund under any state law. Each State is to have an undivided interest in this unemployment fund and may requisition any part of the money held in trust for it.

TITLE VII. MATERNITY AND CHILD WELFARE

For the fiscal year ending June 30, 1936, and for each fiscal year thereafter, there is appropriated $4,000,000 to enable the Federal Government to coöperate with the State agencies of health in extending and strengthening services for the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.

This appropriation is to be administered by the Department of Labor. Ninety-five per centum of the appropriation is to be allocated for the furthering and strengthening of "State and local health services to mothers and children, extending maternity nursing services in counties predominantly rural, and conducting special demonstration and research in maternal care and other aspects of maternal and child health service".

For each fiscal year, the sum of $20,000 is to be alloted to each State by the Secretary of Labor, and the sum of $1,000,000 is to be apportioned among the States in the proportion which the number of live births in each State bears to the total number of live births in the United States as determined annually by the latest available statistics for the United States Birth Registration Area.

The Secretary of Labor may, further, apportion $800,000 "among States unable, because of severe economic distress, to match by themselves in full the amounts made available" under the preceding paragraph, for their use in matching such sums.

The remainder of the appropriation is to be allocated by the Secretary of Labor for special demonstrations and research in maternal care in rural areas, and in other aspects of maternal and child health.

To receive its allotment a State must make available a similar amount, except under certain circumstances, and, through its state agency of health, must submit to the Children's Bureau a state plan which must include "reasonable provision for state administration and supervisory services, for furthering local ma-

ternal and child health services administered by local public health units for State financial participation, and for coöperation with medical, nursing and welfare groups and organizations, and must give due consideration to the development of demonstration services or services of a more permanent character in rural and other needy areas or among groups of the population in special need".

If the Chief of the Children's Bureau deems the submitted plan "in accordance with accepted standards of public health practice developed by Federal Bureaus and other agencies", the plan may be approved and the State may thereby qualify for federal aid.

Care of Crippled Children.—For the fiscal year ending June 30, 1936, and for each fiscal year thereafter, there is appropriated $3,000,000, to be administered by the Department of Labor, to enable the Federal Government to coöperate with state agencies concerned with providing medical care and other services for crippled children.

The sum of $20,000 is to be allotted by the Secretary of Labor to each State, and the remainder, less administrative expenses, is to be apportioned among the States "on the basis of need as set forth in plans developed by the state agencies concerned and approved by the Children's Bureau".

Except in severe economic distress or other exceptional circumstances, no allotment to a state shall exceed the sum made available by the State for similar purposes.

State plans must be approved by the Chief of the Children's Bureau and must include "reasonable provision for state administration, adequate medical care, hospitalization and after care, and coöperation with medical, health, and welfare groups and organizations".

Aid to Child Welfare Services.—For the fiscal year ending June 30, 1936, and for each fiscal year thereafter, there is appropriated the sum of $1,500,000, to be administered by the Department of Labor, for coöperation with the state agencies of public welfare in extending and strengthening, especially in rural areas and areas suffering from severe economic distress, welfare service for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent.

The sum of $10,000 is to be allotted to each State by the Secretary of Labor, and $1,000,000 is to be apportioned among the States in the proportion in which their population bears to the total population of the United States. No allotment may be made to a State in excess of the sum made available by the State for similar purposes.

The remainder of the appropriation, less administrative expenses, is to be apportioned by the Secretary of Labor among the States unable, because of severe economic distress, to match in full the amounts allotted under the preceding paragraph, to be used by such States in matching such sums, or for special demonstrations of methods of community child welfare services.

To receive financial aid, a State must submit plans, acceptable to the Chief of the Children's Bureau.

TITLE VIII. APPROPRIATIONS FOR PUBLIC HEALTH

For the fiscal year ending June 30, 1936, and for each fiscal year thereafter, there is appropriated the sum of $10,000,000, to be administered by the Bureau of the Public Health Service.

The Bureau of the Public Health Service is to allot, annually, $8,000,000 to the several States, "in amounts determined on the basis of the need of each State for such assistance", to develop state health services, including the training of personnel for state and local health work and for the purpose of assisting counties or other political subdivisions of the States in maintaining adequate public health programs.

The sum of $2,000,000 is annually to be made available to the Bureau of the Public Health Service "for the further investigation of diseases and problems of sanitation and related matters".

HOLD-UP OF DR. E. C. LYON

Dr. E. C. Lyon, of Bridgeton, N. J., Secretary of the Cumberland County Medical Society, was the victim of a hold-up at ten o'clock on the evening of January 16, 1935. Dr. Lyon responded to a fake emergency call, and at the alleged destination was met by two masked men who took his watch and money, and drove off with his car. Dr. Lyon informed the police who captured the men before noon the next day, recovering the stolen goods and obtaining confessions from the robbers.

Physicians are subjected to hold-ups so rarely that they are not likely to be on their guard against calls from strangers. Probably the best protection against actual loss is to carry but little money or other valuables.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

FEBRUARY			MARCH		
5	Camden	13 Union	5	Camden	14 Burlington
5	Hudson	14 Burlington	5	Hudson	14 Essex
8	Atlantic	14 Essex	8	Atlantic	14 Passaic
12	Bergen	14 Passaic	12	Bergen	20 Middlesex
13	Mercer	14 Somerset	12	Sussex	21 Gloucester
13	Ocean	20 Middlesex	13	Mercer	21 Morris
13	Salem	21 Gloucester	13	Ocean	27 Monmouth
		27 Monmouth			

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held in the Japanese Room at the Ambassador Hotel January 11, 1935, Dr. C. Coulter Charlton, presiding. There were 75 members present.

The minutes of the December meeting were read and approved.

The Board of Censors approved the application of Dr. Kenneth P. Henderson for active membership. Dr. Henderson was elected.

Applications for membership were received and referred to the Board of Censors from Drs. Williard Mason, J. C. Bitler and Jonas Henry.

GRADUATE COURSES

Dr. W. J. Carrington, reporting for the Postgraduate Committee, stated that one course would be given in March but that the subject had not yet been chosen.

BROADCASTING

Dr. H. S. Read, reporting for the Broadcasting Committee, stated that it was their aim to broadcast two programs each week, on Tuesday at 5.15 p. m. and Saturday at 8.30 p. m., and to have as guest speakers prominent medical men and laymen from New York, Philadelphia, and other places. A motion was carried that each member present, who wished to do so, contribute $1.00 for a fund to carry an advertisement in the Atlantic City Press on the day of each broadcast.

DUES

A letter from the State Treasurer was read stating that the 1935 assessment per member is $13.00. This means that the assessment is an obligation of the County Societies for every voting member on their rolls. The Secretary announced that some members have not paid dues for 1934, and a few members have not paid for earlier years. It is impossible for the society to pay the assessments until dues have been paid by the members.

The By-Laws provide that if any member's dues are not paid by December 31 he shall be automatically suspended. Members more than one year in arrears shall be dropped from the rolls. In view of the communication from the State Treasurer, it is now neccessary for us to abide by the above provision of the By-Laws.

SCIENTIFIC PROGRAM

The Scientific Program was presented by Dr. Jacques Forestier, physician to the Hospital Reine Hortense, Aix-les-Bains, France, his paper being entitled "Rheumatoid (Atrophic) Arthritis and Its Treatment by Gold Salts—A French View of the Question." The discussion was opened by Drs. D. W. Scanlan and W. C. Wescott. Drs. V. E. Johnson and A. J. Davidson also discussed the paper.

It was moved and seconded that Dr. Forestier be made an honorary member for the year in appreciation of his masterly dissertation.

Dr. Charlton announced that the Scientific Program for the February meeting would be presented by Dr. John A. Kolmer. The title of this paper will be "Susceptibility, Immunity, and Vaccination In Acute Anterior Poliomyelitis."

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The annual meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on Tuesday, January 8th, and was called to order by Dr. A. Liva, president. Due to the lateness of the hour the business part of the meeting was postponed until after the Scientific Session.

SCIENTIFIC SESSION

Dr. G. M. Levitas, chairman of the Scientific Committee, introduced Dr. Harlow Brooks of New York who spoke on "Liver Degeneration". He emphasized the fact that the liver cell remains embryonal and reproduces itself even in old age. It is most resistant. He discussed Atrophy, Cloudy Swelling, Fatty Degeneration, Amyloid Degeneration, Hepatitis both the Catarrhal form and the Acute Non-suppurative form, and Acute and Sub-acute Liver Necroses. He mentioned the harm done to an already damaged liver by a high protein diet

and emphasized the importance of treating these patients with a high carbohydrate diet. Sodium thiosulphate is useful in metallic poisoning.

BUSINESS SESSION

Dr. Liva then called the business meeting to order.

The following were elected to membership:

Junior:

Dr. C. A. Abbate, Lodi.
Dr. W. G. Gardine, Bergenfield.
Dr. M. E. Branon, Rutherford.

Associate:

Dr. P. C. Colonna, Englewood.

Regular by transfer from Passaic County:

Dr. Alfred Widetsky, East Paterson.

The following applications for membership were read:

Junior:

Dr. Christian P. Segard, Leonia.
Dr. Ross Vilardo, Jr., Garfield.
Dr. John B. Mauro, Teaneck.

Associate:

Dr. A. P. Randazzo, Garfield.

The president then asked that the committee chairmen submit their reports for publication.

Dr. Sidney I. Franklin moved that Schedule of Clinic Rules as published in the December Bulletin be officially approved by the Bergen County Medical Society. The motion was seconded and passed unanimously.

The president, Dr. Liva, then called for the election of officers for 1935. Dr. S. Alexander moved that the secretary cast a ballot for the men nominated at the December meeting. Dr. P. Liva seconded the motion which was passed unanimously.

The following were the officers elected for 1935:

For President, Dr. David Corn.
Vice-President, Dr. J. H. Irwin.
Secretary, Dr. G. H. Knowles.
Treasurer, Dr. L. A. Markley.
Reporter, Dr. Charles Littwin.
State Nominating Committee,
Dr. Arcangelo Liva.

DELEGATES TO THE STATE MEDICAL SOCIETY
1935-1936-1937

Delegates	Alternates
Dr. F. S. Hallett	Dr. Vincent Farmer
Dr. G. W. Fincke	Dr. H. H. Vandersluis
Dr. E. P. Essertier	Dr. J. B. Edwards
Dr. C. N. Dezer	Dr. J. H. Irwin
Dr. G. M. Levitas	Dr. R. K. Tether
Dr. Charles Littwin	Dr. E. H. Duisberg
Dr. David Corn	Dr. D. B. Hull
Dr. C. A. King	Dr. L. A. Markley
Dr. H. B. Wilson	Dr. F. C. Dilger

Alternate to fill the unexpired term for 1933-1934-1935, Dr. J. Toal.

Dr. Corn stated that the committee chairmen had been named and that they were to appoint their own committees.

Dr. W. L. Vroom read the report of the committee on Bergen Pines, the County Hospital, especially the follow-up of discharged tuberculosis cases. After considerable discussion by Drs. Levitas, Irwin, Huff, Wilson, and Snedecor, Dr. Snedecor moved that a copy of the report be sent to the Board of Freeholders and a copy to the Board of Managers of Bergen Pines. This was seconded by Dr. Littwin and passed unanimously. Dr. Vroom's report was ordered to be filed with the secretary.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The new plan of the society to hold its meetings each month, and in the evening, seems to be working out very successfully. Both the December and January meetings were held at the Moorestown Field Club in Moorestown. The attendance at these meetings was excellent. The general interest in the meetings seems to have increased considerably. In addition to routine business, a rather wide and free discussion of some of the problems of modern medical practice has been indulged in. Dr. Thomas Summey keeps us informed as regards the progress of the Physicians' Lien Law.

The scientific programs have aroused much general discussion. At the December meeting, "Recent Advances in Gynecology and Obstetrics of Practical Value" was presented by Dr. H. P. Shipps. Advances in endocrynology, biologic contraception, obstetrical analgesia, and maternal mortality were briefly discussed. The discussion was opened by Dr. Howard Curtis.

At the January meeting, "Practical Hypersensitiveness" was presented by Dr. Harry L. Rogers, of Riverton, N. J. This was a most enjoyable and complete practical presentation of the subject of allergy. Dr. Rogers not only showed an intelligent understanding of the subject, but he was also able to get it across to his audience. A beautiful demonstration of skin tests was shown on a patient who was present. The discussion was opened by Dr. D. H. Bartine Ulmer.

A resolution presented by Dr. Joseph Stokes, of Moorestown, was adopted and presented to the recently organized Board of Freeholders of Burlington County. The resolution expressed the society's feeling as regards recent political tampering with the organization at the County Tuberculosis Hospital on the ground of present economy. We sincerely hope the Freeholders have or will reconsider their actions, and will enable our tuberculosis hospital to maintain its high standards in caring for the tuberculous patient.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the Camden City Dispensary Building, January 8, 1935, at 9 p. m. The first Tuesday being January 1, 1935, it was considered advisable to postpone the meeting from New Year's night until this date.

POPULAR PUBLICITY

Dr. T. K. Lewis, Chairman of the Public Relations Committee, reported that as a result of a request from the State Society, the Woman's Auxiliary had taken over the function of supplying speakers for radio and public gatherings. In compliance with this request he had turned over to Mrs. Casselman of the Woman's Auxiliary his list of speakers.

NEW MEMBERS

Drs. Elic Denbo and R. R. Roth were given the oath of membership by the President of this society.

Dr. L. S. Hinckley, 211 North Fifth Street, Camden, N. J., was duly elected by ballot to membership.

SCIENTIFIC PROGRAM

The Scientific Program was then presented, the subject being a Symposium on Rheumatic Fever, the program being as follows:

Differential Diagnosis—Dr. H. K. Eynon, Collingswood.
Treatment—Dr. William T. Read, Jr., Camden
The Orthopedic Problem—Dr. B. F. Buzby, Camden.
Nose and Throat Problems—Dr. E. Reed Hirst, Camden.
Eye Manifestations—Dr. H. M. Barnshaw, Camden.

The discussion was opened by Dr. Ralph Hollinshed, of Westville, Gloucester County, by invitation. Other discussions were by Drs. Ciliberti, Hummel, Day, MacAlister and F. William Shafter. Dr. W. T. Read, Jr., closed the discussion.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

Members of the *Cumberland County Medical Society* were guests of the Vineland Training School on the afternoon of Tuesday, January 8, when the society held its regular quarterly meeting with President S. D. Bennett in the chair, and a good attendance of members. Dr. E. H. VanDeusen of the school staff welcomed the physicians.

E. R. A.

Dr. Leslie E. Myatt reported as to the progress of the care of those sick receiving aid from the ERA. There is some difference in the efficiency of the coöperation of the ERA heads and the committee of the Medical Society of the adjoining counties, it was stated. On the whole, in many respects it seemed due to the lack of attention to the details pertaining to submitting the reports. There was a general feeling that considering the mass of details to be carried out, the ERA was very helpful.

IMMUNIZATION

Dr. E. J. Thalheimer, on the request of Dr. C. P. Lummis, chairman of the public relations committee, reported as to the progress of the State Medical Society in its coöperation with the State Board of Health. There seems to be a lack of response on the part of the parents and guardians of children of the pre-school age to have the diphtheria toxoid and vaccination against smallpox given, either during the public hour or at another time. The morbidity and mortality of the children is greater at this age and several deaths have occurred in the county. It is the intention of the public relations committee to enlarge itself so as to be more representative of the township of the county, and to put on an intensive campaign after the subsidence of the present epidemic of whooping-cough about April.

SCIENTIFIC PAPER

The scientific paper of the evening was given by Dr. Louis E. Cohen on the subject "The Surgical Aspect of Tuberculosis of the Lungs."

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter

President John F. Condon presided at the reglar meeting of the *Essex County Medical Society* held at the Academy of Medicine, Newark, Thursday evening, January 10, 1935.

"Compulsory Health Insurance As It Affects Members of the Medical Profession" was the subject of a talk by R. G. Leland, M.D., Director of the Bureau of Medical Economics of the American Medical Association. Dr. Leland is also a member of the technical staff of the Committee on Economic Security of the President of the United States.

Dr. Leland reviewed the status of the physicians in other countries where Health Insurance has been in operation for some time. He pointed out that it was the medical profession itself that had made the advances in the improvement of medical practice, and so it behooves the medical profession now to interest itself in the preservation and protection of these advances. He drew attention to the joker in the health insurance systems whereby physicians are allowed to continue or engage in private practice, that is, if there is then any private practice left in which to engage. He condemned the Epstein bill for Health Insurance that is being introduced into legislatures by the American Association for Social Security throughout the country as being absolutely bad, and suggested that

Medical Societies make their own study of clinic abuse, hospital abuse, the care of the indigent, etc. Referring to group hospitalization plans, an example of which exists in Essex County, he advised that care be exercised to hold strictly to hospital care, including no medical services as laboratory, x-ray, or anaesthetic.

He said that while the A. M. A. had been criticized for not preparing a Health Insurance plan for the nation, it would be impossible to do such a thing because of the widely varying conditions in the different states and even in parts of the same states. He recommended that medical societies develop trial plans, testing them against the ten principles adopted at the last A. M. A. meeting in Cleveland. Medical societies ought to experiment with new methods of rendering medical service to their communities, accumulate experience, and produce unified thinking and action by physicians. Individuality should be preserved in the practice of medicine, but there should be organization in the economics of medicine. Lastly, no lay organization should be allowed to make a trade of business in the practice of medicine.

State President Ely favored the meeting with his presence, and expressed his reaction to the problems at hand.

The following new members were elected:

Regular—

Charles D. Altman, Newark, L. I. Coll. Hosp, 1924.
William Lloyd James, Newark, U. Pa., 1921.

Associate—

Russell M. Coleman, E. Orange, Howard Univ., 1933.
Leon Levins, Newark, U. Pa., 1929.
Nathan Miller, Irvington, G. W. Univ., 1933.
Arthur J. Statman, Newark, Univ. Md., 1932.
Elizabeth B. Wood, Newark, Wom. Med., 1932.

HONOR TO DR. H. H. KESSLER

Essex County points with pride to the honors recently bestowed on its member, Henry H. Kessler, of Newark. On January 14th, he delivered the Hunterian Lecture at the Lord Mayor's Mansion House, London, before the Hunterian Society of England. His subject was "The Contribution of John Hunter to the Rehabilitation of the Crippled and Disabled".

Two Americans who have been similarly honored previously by the Hunterian Society are John M. Finney and Howard A. Kelly, both of Johns Hopkins.

Dr. Kessler has also been notified by Columbia University that it will shortly award him the degree of Doctor of Philosophy. The Columbia University Press is publishing his second book, "The Crippled and Disabled". His first book, "Accidental Injuries", appeared a few years ago from the press of Lea & Febiger.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its monthly meeting on January 17, 1935, in the Hotel Pitman, Pitman, with Dr. Edwin Ristine, of Westville, President, in the chair, and twenty-one members present.

The evening was devoted to a scientific program in which Dr. Edward Weiss, of Temple University, Philadelphia, spoke on "Hypertensive Disease", with special reference to malignant hypertension.

Following the meeting, the doctors and members of the Woman's Auxiliary enjoyed a buffet supper.

Those present were: From Woodbury—Drs. H. B. Diverty, Dorothy Rogers, E. E. Downs, Harry Nelson, Duncan Campbell, J. H. Underwood, Paul M. Pegau and F. G. Sherman. From Williamstown—Drs. H. M. Fooder and H. W. Wright. From Pitman—Drs. W. B. Chalfant, M. F. Lummis, I. W. Knight. From Glassboro—Dr. William Pedrick. From Westville—Drs. Edwin Ristine and R. K. Hollinshed. From Gibbstown—Dr. C. I. Ulmer. From Swedesboro—Dr. B. A. Livengood. From Paulsboro—Dr. H. L. Sinexon. From Mickleton—Dr. A. B. Black. From Mantua—Dr. Louis Ruttenberg.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club on Tuesday, December 4, 1934. The meeting was called to order by the President, Dr. E. J. Chapman, at 9.30 p. m. The minutes of the previous meeting having been printed in the Bulletin were accepted as printed.

The Executive Committee recommended that the President, Secretary and Treasurer be authorized to investigate and make use of funds for indigent doctors.

SPEAKERS' BUREAU

The Woman's Auxiliary to the Hudson County Medical Society has been requested by the State Medical Society to establish in Hudson County a "Speakers' Bureau". Through this bureau, speakers could be furnished to local health and welfare organizations gratis. In this way, the laity would be intelligently informed on many important matters of health. Referred to Publicity Committee for action and report.

REPORTERS AS DELEGATES AT ANNUAL MEETING

Dr. Connell said that at the recent meeting of the Secretaries and Reporters held at the Stacy-Trent Hotel, Trenton, N. J., November 7, 1934, which was attended by Drs. Connell and Brennock, the question came up as to whether or not the reporters should be made delegates to the State Convention. The status of the Reporters at the present time is as follows: He goes to the State Convention, but has no official standing as a delegate. He was requested to sound out the feeling of his County Society in reference to this matter. It

was regularly moved and seconded that this matter be presented before the members of the Society at the next regular meeting.

NEWS ITEMS TO DAILY PRESS

There was a discussion relative to the giving of news to the papers. No formal action was taken. It was the prevading opinion that all news pertaining to the Hudson County Medical Society be given out through the Chairman of the Publicity Committee and no other person.

THE PUBLICITY COMMITTEE—DR. THOS. HIGGINS, CHAIRMAN

The Publicity Committee has gone ahead with the radio programs as authorized at the general meeting of the society. Without any cost to us, radio station WAAT has given us fifteen-minute periods every Saturday, 12:15 to 12:30; Sundays, 9:30 to 9:45, and on Mondays, 12:15 to 12:30. The program has been as follows:

Nov. 10, Dr. William N. Barbarito, "Infections of the Hand".
Nov. 11, Dr. Thomas McG. Brennock, "Cancer".
Nov. 12, Dr. Harry J. Perlberg, "Use of X-Ray in Medicine".
Nov. 17, Dr. Martin I. Marshak, "Tuberculosis".
Nov. 18, Dr. A. P. Rieman, "Surgery of the Chest".
Nov. 19, Dr. James Norton, "Prenatal Care".
Nov. 24, Dr. S. A. Sandler, "Mental Hygiene".
Nov. 25, Dr. A. E. Olpp, "Obesity".
Nov. 26, Dr. H. R. Furlonge, "Whooping Cough".
Dec. 1, Dr. Frank Perlstein, "Leukemia".
Dec. 2, Dr. J. P. Coughlin, "Blood Pressure".
Dec. 5, Dr. E. A. P. Peters, "Gall-Bladder Disease".
Dec. 8, Dr. G. Ginsberg, "Diabetes".
Dec. 9, Dr. S. Selinger, "The Diseased Tonsil".
Dec. 10, Dr. P. D'Acerno, "Complications of Pregnancy".
Dec. 15, Dr. F. J. McLoughlin, "Goitre".
Dec. 16, Dr. A. P. Blakey, "Anesthetics".
Dec. 17, Dr. Arthur Justin, "Heart Disease".

On January 5th, our talk will be on "Hygiene". On January 6th, we will give advice on correct "First Aid Treatment of Minor Injuries", and on January 7th, the talk will be on the "Preventable Diseases of Childhood". We will have the coöperation of the school authorities in this series of three lectures. The talks will be in simple language so that every school child will profit by the advice given. The school teachers will review the practical points brought out in these three lectures on Hygiene, First Aid, Preventable Diseases, and in this way the children will be receiving practical medical instruction directly from the doctors of the Hudson County Medical Society.

All of the doctors who have been kind enough to give their services on our radio programs have enjoyed the experience. The committee extends a cardial invitation to every member of the Hudson County Medical Society to take part in the broadcast of medical talks.

The committee suggests that the members of this society listen in to our programs whenever possible, so they will be acquainted with the messages which we are carrying to the public and be thus better prepared to carry out our suggestions when new patients consult the doctor as a result of our radio broadcasts. Much of the success of our broadcasting program depends on what each doctor does for the patient when he presents himself for examination or treatment.

PUBLICITY COMMITTEE

The Publicity Committee has distributed circulars discussing immunization against whooping cough. This treatment was discussed on one of our radio talks and several patients have already undertaken the immunization of these children as a result of the talk. Your Publicity Committee would like every member of the society to be familiar with the treatment so that they can discuss it and give the treatment to those patients who seek it.

We have had requests for speakers from outside organizations. Your Publicity Committee at present has no list to work from of those doctors who are willing and desirous to give occasional talks before public gatherings, and it will appreciate volunteers for this service. (See paragraph on Speakers' Bureau.)

REPORT OF PUBLIC HEALTH COMMITTEE

Dr. Jaffin read the report of the Public Health Committee meeting which was held at the Medical Center November 22, 1934, at 4:30 p. m. After reorganization and reëlection of the former officers, the committee decided to concentrate on three or four principal activities for the present.

Dr. Forman will continue with his sub-committee on the *diphtheria* project. Dr. DeFuccio, Dr. Forman and your Chairman will take up the matter of *garbage and litter* with the city officials. Dr. DeFuccio's aid in this respect will be of particular value because of the fact that as a member of the Board of Education, he will be able to accomplish a good deal of educational propaganda through the schools. It is hoped that this will be a powerful measure in counteracting many of the evils traceable to youthful delinquency.

Dr. Halligan is to take charge of *educational* efforts, aiming at the reduction of the mortality from appendicitis. The committee agrees with him that a public knowledge of the dangers of delay, of cathartics and other factors, if brought to the attention of the public, would go a long way toward the reduction of the death rate.

The question of *tuberculin survey* was thoroughly discussed, and after further deliberation by the newly organized committee will be reported upon with recommendations after the next meeting.

Dr. Jaffin stated that he received a cordial invitation from Commissioner Fagan, Commissioner of Streets and Public Improvements, who stated that he would, in the very near future, arrange a meeting with the Public Health Committee to discuss better methods of the collection and removal of garbage and ashes. It is the primary aim of the Public Health Committee to devise ways and means to raise the pride of the people of this city to the

new and up-to-date methods of garbage and ash removal.

Dr. Jaffin also brought up the question of tuberculin survey, and he stated that the committee is alive to the fact that there is a certain amount of feeling on the part of the members that this should not be done in schools but by the family physicians; and we have come to the conclusion that Tuberculin Survey should be done in the high schools and referred back to their family physicians.

JANUARY MEETING

The regular meeting of the *Hudson County Medical Society* was held on Wednesday, January 2, 1935, at the Carteret Club. The meeting was called to order by the President, Dr. Chapman, at 9.35 p. m.

RADIO BROADCASTS

Dr. Thomas Higgins for the Publicity Committee reported that a placard announcing the day and time of our radio broadcasts has been mailed with each copy of the Bulletin. The committee asks that doctors display the card in their reception rooms so that the public in general will know of our broadcasts and listen in to them.

The broadcasts are continuing three times each week and the response has been very favorable. The program of speakers is about 80 per cent filled into the month of April. The Publicity Committee extends a cordial invitation to every doctor of this society to take part in our program. Get in touch with a member of the Publcity Committee by mail or phone. The Publicity Committee has received the endorsement of the Executive Committee of a program which contemplates the publishing of our radio talks in the local newspapers. Dr. Olin West of the A. M. A. has advised Dr. Higgins that it was advisable and desirable to give the name of the doctor who prepared the article, providing the articles are always published under the heading of "Hudson County Medical Society".

AUTOMOBILE INSIGNIA

The Publicity Committee has recommended the use of an insignia, three and one-half inches in diameter, for the front and back license plates of the automobiles of our members. The insignia is to bear the wording "Physician—Hudson County Medical Society", with a small red cross in the center. Upon inquiry, the American Red Cross advised Dr. Higgins that an Act of Congress in 1905 designated that the Red Cross be used by the American Red Cross and by the Medical and Sanitary Departments of the United States Army and Navy. The committee knows, however, that this insignia is extensively used otherwise, and will ask for the opinion of the society on this matter.

As a result of the use of this insignia, the Publicity Committee is planning to arrange for concessions by the Police Departments to be granted to doctors using their cars on sick and emergency calls. The aim is for a thirty-minute parking privilege for doctors in restricted areas. The matter has been discussed with some of the police authorities, and they have promised coöperation.

Dr. Marshak moved that the report of the Publicity Committee be received and its recommendations adopted. Seconded and carried.

PUBLIC HEALTH HOUR

Dr. Jaffin, for the Public Health Committee, stated that he was very much pleased to see that the members of the Hudson County Medical Society were at last getting in back of the *Public Health Committee* in putting over the *Public Health Hour* idea.

There was a lengthy discussion regarding two proposals for the detection of tuberculosis among school children. The opposition of the Radiological Society of New Jersey to x-raying all school children indiscriminately was popular with the members. A proposition to approve testing all the children with tuberculin was defeated.

SCIENTIFIC

The program of the scientific session consisted of a paper by Dr. N. B. Van Etten, New York, Vice-Speaker of the House of Delegates of the American Medical Association, on "How Shall the Sick Be Adequately Served, and the Servants of the Sick Paid?" (See page 98.)

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on the evening of January 10, 1935, President Cottone presiding.

Drs. H. L. Drezner, Robert Forer, F. M. Hammell, Elizabeth L. Martin, P. B. Reisinger, S. E. Watov and M. R. Zentner were elected to active membership in the society.

The applications of Drs. I. P. Davenport, G. N. J. Sommer, Jr., and Joseph S. Kondor were read and referred to the Membership Committee.

A communication from Lawyer Crawford Jamieson relative to the hearing on the Schedule of Fees to be held February 8th at 3 p. m. in the Common Pleas Court Room was read and the motion made and carried that the Secretary be authorized to send notices of this meeting to the members of the society.

The greater part of the evening was given over to a discussion of local aspects of the Emergency Relief Administration.

Dr. Wilbur Watts, Chairman of the Mercer County Advisory Committee to the Emergency Relief Administration, reported on some unsatisfactory rulings of the State Emergency Relief Administration Council, particularly that those physicians receiving substantial salaries in governmental positions should not be eligible to receive remuneration for treating the sick poor under the E. R. A.

Dr. S. T. Snedecor, Chairman of the State Advisory Committee to the E. R. A., described the efforts of his committee to impress the medical point of view upon the official administrative council,

which is composed of non-medical men. He suggested that representatives of the Mercer County Medical Society appear before the State Administrative Council, which would hold a meeting in the near future. It was understood that the suggestion would be carried out.

MORRIS COUNTY

Dr. Marcus A. Curry, Reporter

Another of a series of *"Clinical Club"* meetings of the *Morris County Medical Society* was held at the State Hospital at Greystone Park the evening of Thursday, January 17, 1935.

President McMahon opened the meeting and there were present between sixty and seventy members and guests.

The program was put on by members of the medical staff of the State Hospital, as follows:

Mental Hygiene as Applied to the General Practitioner—By Dr. Arthur G. Lane, Clinical Director (10 minutes).

Dementia Precox, Its Symptoms, Diagnosis and Treatment, with Demonstration of Cases—By Dr. Thomas G. Peacock, Senior Resident Physician (10 minutes).

The Affective Psychosis, with Demonstration of Cases—By Dr. Malcolm C. Taylor, Resident Physician (10 minutes).

Psychopathic Personality, with Demonstration of Cases—By Dr. Laurence M. Collins, Senior Resident Physician (10 minutes).

General Paralysis, Its Symptoms, Diagnosis and Treatment—By Dr. Thomas B. Christian, Pathologist (10 minutes).

The Endocrines and Their Relation to Mental Disease, with Demonstration of Cases—By Dr. John Kinley, Resident Physician (10 minutes).

Traumatic Brain Injuries, with Demonstration of Cases—By Dr. Laurence M. Collins, Senior Resident Physician (10 minutes).

Psycho-Neurosis, with Presentation of Cases—By Dr. L. R. Harrison, Resident Physician (10 minutes).

The interest in the program was manifested not only by applause but by the discussion which was liberally entered into by the general practitioners. The questions asked received explanatory answers by the various staff physicians who presented papers and demonstrated them by presenting patients typical of the various psychoses.

President McMahon crystalized the sentiment of the members by stating that we are all indebted to Superintendent Curry and the other gentlemen for making the facilities available, and for the presentation of the interesting cases and thanking each in behalf of the society.

At the conclusion of a very interesting scientific chapter refreshments were enjoyed in the hospital cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held Thursday, January 10th, 1935, at 9 p. m. at the Board of Health, Paterson, N. J., Dr. Wright MacMillan presiding.

INAUGURAL

Dr. MacMillan opened the meeting with a brief but inspiring talk on what he hoped would be accomplished during his term of office. He mentioned the problems that confronted the society, and expressed the wish that the ideals of our profession would be held up and maintained while we sought a solution of the pressing difficulties confronting us today.

SCIENTIFIC

Dr. MacMillan then introduced the speaker of the evening, Dr. Horace R. Baldwin, Clinical Professor of Medicine, Cornell University Medical College, New York City, who gave a very interesting and illuminating talk on the "Treatment of Pneumonia", which was enjoyed by all.

Dr. Samuel Ginsburg opened the discussion, followed by Dr. Kovin and Dr. Bergen.

COMMITTEES

Dr. MacMillan announced the appointment of the following committees:

Legislative

N. M. Dingman, *Chm.*	E. J. Marsh
A. F. McBride	H. S. Willard
T. E. Manly	L. F. Cole

Public Health

N. M. Dingman, *Chm.*	A. H. Van Erde
F. P. Lee	H. W. Laauwe
H. M. Gochman	G. G. Walton
John N. Ryan	L. F. Melony
Ed. I. Ives	Morris Joseph

E. R. A.

T. A. Clay	Fred Vosburgh
J. Roemer	H. S. Willard
C. J. Murn	

Lien Law Advisory

W. W. McAlister	Henry E. Dwyer
Wm. Spickers	H. C. Reynolds
F. W. Ash	

Constitution and By-Laws

C. J. Murn	W. W. Hall
C. R. Mitchell	

Dispensary Abuse

T. A. Clay	N. M. Dingman
I. Okin	J. Roemer
A. Kroll	H. J. Udinsky
William Dwyer	N. Ginsburg

Program

Fred Vosburgh, *Chm.* A. J. DeLario
S. A. Levinsohn

Economics

J. S. Yates J. Roemer
Samuel Ginsberg

GRADUATE COURSES

Dr. Hall then opened the question as to whether the post-graduate course of lectures were to be repeated this year. After discussion from the floor, Dr. Bergen made a motion which was duly seconded and unanimously passed, that the Post-Graudate Course be given this year, and should consist of eight lectures to be held on Tuesday afternoons at 4 p. m.

ECONOMICS

Dr. Yates then opened a discussion on the need of informing the members of all the phases of economic legislation affecting physicians, and the need for discussing the economic problems confronting the profession at this time. After a great deal of discussion, Dr. Roemer made a motion which was duly seconded and unanimously adopted, as follows:

"Resolved, that a committee be appointed by the chair to report and discuss before the society at every regular meeting following the scientific program, all questions pertaining to the economic problems now facing the medical profession; and also to study and report on all pending proposed legislation affecting the medical profession."

Dr. MacMillan then appointed the following committee: Dr. Yates, Dr. Ginsburg, Dr. Roemer.

NEW MEMBERS

The following members were unanimously elected to membership: Meyer Notkin, Irene J. Zalewski, Irving Ehrenfeld.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The rgeular meeting of the *Somerset County Medical Society* was held at the Nurses' Home of Somerset Hospital on December 13, 1934. The meeting was called to order at 8:30 with the following members present: Drs. Albrecht, Baker, Barbour, Cook, Ely, Field, Greenberg, Halstead, Hegeman, Lawton, Lovejoy, Lukats, McConaughy, Meigh, Pigott, Pogaloff, Panigrossi, Renner, Smalley, Stillwell, Scott, Sferra. The guests present were Dr. A. J. Casselman, of the United States Public Health Service, and Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey.

The Public Health Committee reported its progress in the recent toxoid injection program. The Secretary also called attention to the society of the notifications sent to each Board of Education and Board of Health of Somerset County in reference to the Permissive Law whereby the Boards of Education can compel the school children to receive preventive treatment for smallpox.

The Post-Graduate Committee, represented by Dr. Renner, rendered its report, showing substantial progress in the project.

The Fee Schedule Committee reported that unusual pressure brought to bear by the State Bar Association and certain insurance companies made it advisable that the Somerset County Medical Society mark time and wait for a test case which will soon come before the courts in another county.

The Board of Censors recommended Dr. John Gordon Ross, of Basking Ridge, for membership and he was duly elected. The application of Dr. Howard F. Day, of North Plainfield, was presented before the society. It was referred to the Board of Censors for consideration.

Dr. Wilkes spoke on some points of interest in current State Medical Society activities, particularly the Public Health Hour. He pointed out that our county was unusually well represented in the results tabulated at the State Department of Health.

Our guest speaker, Dr. Casselman, then gave an interesting talk on "Diagnosis and Treatment of Syphilis".

Light refreshments were served, and the meeting adjourned.

WESTFIELD MEDICAL SOCIETY IN UNION COUNTY

Reported by Frederick A. Kinch, M.D.

The regular monthly meetings of this society have been held as follows:

November 13th—Speaker, Dr. Charles F. Baker, Newark; subject, "Co-relation of X-Ray and Clinical Diagnosis of Peptic Ulcer", illustrated by Roentgen films.

December 11th—Speaker, Dr. John E. Runnull, Bonnie Burn Sanitorium; subject, "Surgical Treatment of Pulmonary Tuberculosis", illustrated by x-ray films.

January 8th—Speaker, Dr. T. H. Robie, Maplewood; subject, "Psychiatry in Relation to the Treatment of the Mentally Deficient and Birth Control".

All these papers have been very interesting to the large attendance, and elicited free and instructive discussion.

GASTRO-ENTEROLOGICAL SOCIETY

Reported by J. Gerendasy, M.D., Secretary

New Jersey Gastro-Enterological Society held a scientific meeting November 19, 1934, at the Academy of Medicine of Northern New Jersey.

Dr. Martin E. Rehfuss of Philadelphia, Pa., spoke on "The Medical Treatment of Gall-Bladder Disease."

The surgical aspect was presented by Dr. Edgar Burke of Jersey City Medical Center.

Interest in the meeting was demonstrated by a large attendance of physicians from all parts of the state.

Dr. J. S. McDede of Jersey City, and Dr. S. Ben-Asher of Newark, were inducted into the society.

The members are looking forward to the organization meeting of the Section on Gastro-Enterology on May 2, at the Annual Meeting of The Medical Society of New Jersey.

SOCIETY OF SURGEONS OF NEW JERSEY

The newly elected officers of the *Society of Surgeons of New Jersey* are as follows:

President, Dr. Briscoe B. Ranson, Jr., of Maplewood

First Vice-President, Dr. Herbert W. Nafey, of New Brunswick

Second Vice-President, Dr. Samuel A. Cosgrove, of Jersey City

Secretary, Dr. Walter B. Mount, of Montclair

Treasurer, Dr. George P. Blackburne, of Newark

The annual meeting of the society was held on Wednesday, January 9th, 1935, at the Hotel Douglas, Newark, N. J. The program was as follows:

Morning Session

"The Adrenal Sympathetic System and Its Diseases", George W. Crile, Cleveland.

"Obstructive Lesions of the Uterus and Their Complications", Arthur H. Curtis, Chicago.

Luncheon.

Afternoon Session

"Diagnosis and Treatment of Disturbances of the Cranial Nerves", Walter E. Dandy, Baltimore.

"Injuries in the Region of the Elbow", Philip D. Wilson, New York.

"Present Status of the Prostatic Problem", Henry G. Bugbee, New York.

"Management of Carcinoma of the Large Bowel", W. Wayne Babcock, Philadelphia.

6 p. m.—Annual business meeting.

7 p. m.—Banquet. Richard D. Freeman, President, Toastmaster, South Orange.

Speakers

Rev. S. Parkes Cadman, D.D., LL.C., Brooklyn.

Sir Gerald Campbell, British Consul-General, New York.

OBITUARIES

DR. FRANK C. SHIPMAN

Dr. Frank C. Shipman, a practicing physician in Jersey City for more than a quarter of a century, died at his home, 3663 Boulevard, Friday evening, January 4, 1935. Death was caused by hemorrhage resulting from carcinoma of the tongue.

Dr. Shipman was born in Bloomsburg fifty-five years ago. He attended grammar and high-school at Phillipsburg, and studied medicine at the New York Homeopathic Medical College and Flower Hospital, where he received his degree of Doctor of Medicine in 1908. His academic work was taken at Lafayette College, Easton, Pa. He began the practice of medicine in Phillipsburg in 1909, and came to Jersey City in 1910.

Dr. Shipman was a member of the Medical Societies of his county and state, and of several fraternal orders.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING DECEMBER, 1934

Supplied by the State Department of Health

NAME	AGE	DATE DEATH	PLACE OF DEATH	RESIDENCE	CAUSE OF DEATH
Edwin K. Dunkel	70 Yrs.	Dec. 7	State Hosp., Parsippany	Jersey City	Ac. cardiac dilatation. Psychosis.
Albert E. Frey	71 Yrs.	Dec. 27	Elizabeth	Hillside	Fracture of skull, in auto accident.
Louis D. Henn	59 Yrs.	Dec. 12	North Plainfield	Same	Chronic endocarditis.
Chas. F. Hitchner	90 Yrs.	Dec. 15	Elmer	Same	Coronary thrombosis
Max Ignatoff	32 Yrs.	Dec. 25	Beth Israel Hosp., New'k	Newark	Malignant hypertension.
Augustus F. Kempton	79 Yrs.	Dec. 6	Ventnor City	Same	Chronic nephritis.
Charkley J. Killie	79 Yrs.	Dec. 18	Co. Hosp., Pemberton	Moorestown	Chronic myocarditis.
Marius J. Pace	28 Yrs.	Dec. 23	City Hosp., Newark	Brooklyn, N. Y.	Carcinoma of lungs.
Lewis S. Pilcher	89 Yrs.	Dec. 24	Upper Montclair	Same	Chronic myocarditis.
Benjamin A. Robinson	72 Yrs.	Dec. 8.	Sayreville	Same	Lobar pneumonia.

THE WOMAN'S AUXILIARY

Atlantic County

Reported by Mrs. James H. Mason Publicity Chairman

The Executive Board of the *Woman's Auxiliary to the Atlantic County Medical Society* met on Friday, December 28, 1934, at the home of the President, Mrs. James North. The Chairman of Membership, Mrs. Blair Stewart, reported a total of eight new members since October.

Mrs. John Massey, Chairman of Public Relations, reported for the Speakers' Bureau project and read the list of speakers and their subjects submitted by the County Medical Society. A total of twenty-five physicians have volunteered to speak upon a variety of subjects.

The regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held on Friday, January 11, 1935, 8 p. m., at the Ambassador Hotel. The First Vice-President, Mrs. Carl Surran, presided.

Dr. Clarence Andrews spoke to the members explaining the benefits of the Widows and Orphans Relief Society. The Committee Chairman reported the same as for the Executive Board meeting.

Mrs. John Massey, Public Relations Chairman, announced two tentative engagements for speakers.

Plans were discussed and suggestions made for raising funds for the reciprocity tea to be held late in March or early in April.

An announcement of a health program planned and supervised by our Secretary, Mrs. Lawrence Wilson, to be held January 17th at schoolhouse in Absecon, was made.

Following the business meeting a most interesting review of the book "Full Flavor" was given by a member of the county society, Dr. Clara K. Bartlett. There were thirty-four members present.

Gloucester County

Reported by Mrs. Henry B. Diverty

The *Woman's Auxiliary to the Gloucester County Medical Society* held its regular meeting January 17th at 9 p. m. at the Hotel Pitman.

The President, Mrs. J. Harris Underwood, presided. The membership was very well represented. After the business meeting was adjourned a social hour followed. The ladies joined the doctors in the dining room, where refreshments were served.

Hudson County

Reported by Caroline Culver

DECEMBER MEETING

Instead of the regular monthly meeting with business and a guest speaker, a musical program and motion pictures entertained the members of the *Woman's Auxiliary to the Hudson County Medical Society* on Monday afternoon, December the tenth, in a Christmas party held at the Y. W. C. A. The President, Mrs. Frank P. Nicholson, presided and introduced the entertainers. Mrs. John Connell was chairman of hostesses.

Richard Blondel, of the Radio Story Teller's Hour of WABC and WOR, read a beautiful Christmas story anent the tolling of the silver chimes; also a story about trees, while Mrs. Harry Perlberg, one of our talented members, played a piano accompaniment.

Madame Phyllis de Rosa, soprano, sang several opera selections, with Reno Taverna at the piano, and later many songs and carols with Mrs. Perlberg accompanynig.

Another contributor to the pleasure of the day was Ernst Geisendorfer, a student at Columbia, who showed an interesting motion picture of the old town of Rothenberg, where his ancestors lived for several centuries and where he was born. The town's history includes much of interest, and the talk centered around the Thirty Years' War and many of its incidents of especial interest.

Accordion selections by Felix Restivo (who was most generous with his numbers) completed the program.

Tea followed. The table was gay with the red and green of the Christmas season.

JANUARY MEETING

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday afternoon, January the seventh, at the Y. W. C. A., the President, Mrs. Frank P. Nicholson, in the chair.

The minutes of the previous meeting were read and approved.

The Treasurer's report was accepted as read.

The Chairman of the Widows' and Orphans' Relief Fund made another plea for subscribers to this fund, and application blanks were handed to all who would accept them.

Mrs. Edward G. Waters, the new Chairman of *Speakers' Bureau and Public Relations*, reported that the doctors who were heard over WAAT were available for health talks if needed.

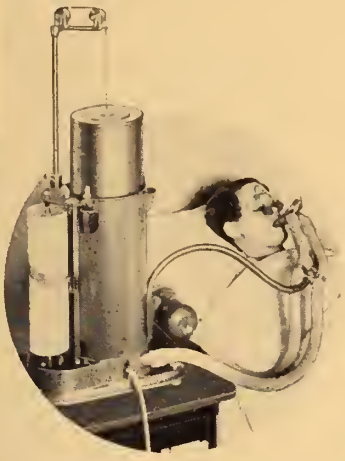
The Chairman of Entertainment, Mrs. Charles B. Kelley, gave a splendid report of the luncheon and card party held in New York at the Barbizon-Plaza in December, at which time we cleared nearly $125 for our charity fund.

Plans for a theatre party for members and their guests were discussed, and although no positive date has been selected, this will probably occur before the beginning of Lent.

The President spoke of the State Executive Board Meeting to be held in Trenton on Monday, January fourteenth, at the Stacey-Trent.

We had no guest speaker, as there was much to discuss concerning the plans for mid-Winter.

Later tea was served when Mrs. S. B. Barishaw, as Chairman of Hostesses, was assisted by an able committee.



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ANNUAL MEETING, ATLANTIC CITY, APRIL 30, MAY 1 and 2

THE JOURNAL

OF

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Offices of the Society, 137 East State Street, Trenton, N. J.

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OF
THE MEDICAL SOCIETY OF NEW JERSEY

Under the
Direction of the
Committee on Publication

Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

Publishing the Annual Reports

Last year when the officers and committee chairmen were asked to prepare their annual reports for publication in the May Journal, an impression was prevalent that the suggestion was an innovation and that "it had never been done that way before". As a matter of fact "presessional reports" had been printed in every May issue of the Journal beginning with 1928. in accordance with the following resolution which was passed by the House of Delegates on June 10, 1927:

"The report of the Board of Trustees and the reports of committees which are to be acted on in the sessions of the House of Delegates shall be printed in the Journal a month before the meeting, in order that the delegates may be acquainted with the business that is to come before them."

The discussion of this motion, filling a page of the 1927 "Transactions", centered around a proposal that reprints of the reports be brought to the meeting for the use of the delegates when they arrive. One delegate put forth the argument that "We may read it in the Journal a month beforehand and then forget what it was; or we misplace our Journal and forget about it". The proposal was voted down in 1927, but last year reprints of the reports were made and a copy was mailed to each delegate before the meeting.

The resolution of the House of Delegates passed in 1927 will be carried out this year, as it was in 1934; and the Annual Reports will appear in the April issue of The Journal. Also reprints will be available to the delegates and the Reference Committees.

Furthermore, copies of the Transactions of the House of Delegates of the years 1927-1934 have been bound in a single volume which will be available for reference at the sessions of the House.

The coming session of the House of Delegates should give peculiar satisfaction to all members of the State Society. Every project adopted last year has received consideration by the officer or committee to whom the activity was assigned and in practically every instance it has been carried out. This excellent record has been achieved largely by the follow-up system which centers in the Executive Offices, and by which a definite response is secured from those participating in the activity.

Recognition of the State Medical Society

A subscription to The Journal has been received from a great business organization whose activities are closely interwoven with health. This organization has watched the work of The Medical Society of New Jersey, and is interested in the efficiency of its organization and its prospects of great accomplishments, particularly in these times of suggestions of revolutionary methods of practice.

The individual physicians of New Jersey, as are those of all other states, are noted for their ability to treat individual sick patients. But the Medical Societies of the State are outstanding in their outlook upon the fields of activity of allied groups whose coöperation is necessary for the establishment of a complete system of delivering medical services to all citizens.

Revolutionary changes come suddenly and are accompanied with suffering and discontent. On the other hand, the participants in an evolutionary movement are often too close to the scene of action to be aware of the extent of the progress which they are making. But a business organization with nation-wide contacts is in a position to judge the comparative accomplishments of medical societies in adapting time-honored methods of practice to new conditions. A Journal subscription from such an organization is a recognition of the efficiency of The Medical Society of New Jersey.

Health and the Economic Depression

The effects of the five years of intense economic depression on health have been the subject of many discussions. There was a general expectation that morbidity reports and vital statistics would show a great increase in sickness and deaths, but the reports for 1930 from all over the United States showed a higher state of health than ever before. Then came predictions that the people were living on their "Health Capital" and that the reports in future years would reveal the accumulated effects of want and suffering, and that sickness and death would probably increase. The fact is that the vital statistics for 1931, 1932, 1933 and 1934 showed an increasing degree of healthfulness.

The reasons for the lowered morbidity and death rates have been widely discussed. One reason for better health showing was often given as the absence of widespread epidemics. The credit was often ascribed to the efficiently organized services provided by official and private health organizations.

The official announcement of one State Department of Health reads:

"But the basic reason why the mortality rates have not increased is the fact that the State and federal governments have assumed ever greater responsibility for the maintaining of life among the millions of unemployed and their families. One does not care to think about the possible consequences, not only in the field of health, but in our entire social organism if the critical situation had been left to indivdiual initiative to resolve."

It may well be that the enforced frugality in eating is reflected in a higher standard of health. The standard diet of the people during the years of depression has generally been higher than that of the average family during the decades of the sixties and seventies; and old clothes have been as warm as new ones of a fashionable cut. If lack of proper clothing produces sickness, the bare-legged children of the well-to-do should have showed a great susceptibility to pneumonia and rheumatism, but they do not seem to have suffered from the lack of clothing.

Seldom has credit been given to practicing physicians for their part in promoting better health conditions. The journals of all the State Medical Societies have carried announcements of the physicians that they stood ready to serve the people in sickness regardless of their ability to pay for the services. Never has there been a complaint that the doctors have failed

to give their services, without which all the money spent for relief would have been ineffective.

The physicians of New Jersey have been a major factor in maintaining a high standard of health in the State. The success of the Emergency Relief Administration in medical relief has been the result of the initiative of the physicians in devising a practical system of medical coöperation, and securing its adoption by the E. R. A. at the very beginning of the relief organization. The suppression and prevention of epidemics in New Jersey has depended primarily on the efficiency of family physicians in detecting, reporting, and treating patients in the early stages of contagious diseases.

The work of the doctor has been the basis on which the health and relief groups have given service. It is time that practicing physicians and their own organizations should assert their just share of credit for the increased standard of health during these years of depression.

The School of the County Society

A physician is eligible for admission into a county medical society because he is one of the favored few to whom a license to treat the sick has been given by the state. In return for this special privilege, physicians have voluntarily set high standards of knowledge, skill, and ethics, which are enforced by the medical societies of the Counties, the States, and the Nation.

County societies originated as a teaching and examining body in which membership conferred the right to practice medicine,—a prerogative whose memory is preserved in the name of one State Society, "The Medical and Chirurgical Faculty of Maryland". While the medical societies of all the States have yielded some of their legal powers to the medical schools and the State, they still retain their essential power of maintaining the high standards of ethical conduct and scientific practice for which the medical profession is everywhere noted.

The county medical society is a continuation school in which every physician is expected to enroll for life. Its departments and activities are those of his undergraduate medical school, amplified, and adapted to the status of its members as independent practitioners of medicine. It has its courses of instruction, its customs and traditions, and its standards of ethical conduct to which it requires strict conformity.

Every physician who formally enrolls in the school of the County Society is expected to take part in the activities of its fundamental departments of graduate education, economics, public relations, and fraternity. He will partake of the benefits of every department; but that in which he is prominently active will depend largely upon his temperament and talents. He will benefit most when he takes part in that activity to which he is especially fitted.

Every member of the school of the County Medical Society is graded by his colleagues both in his contributions and also in his acquirements or receptiveness to the influences of the school. A few outstanding leaders rate high for their contributions in all four departments of society activity; but an equally high rating is accorded to the modest member who appreciates the benefits which he receives, and does the task which is assigned to him.

Graduate Education

The Medical Society is a *Graduate School* of Medical Practice. Experience is its most efficient teacher, and research is its basic method of study. New methods of diagnosis and treatment are subjected to analysis and criticism, and facilities are provided for publishing works of merit in the medical journals. It is expected that every member will be a teacher as well as a learner, for he will impart his discoveries to others, and in return he will receive instruction from his colleagues.

A scientific paper or demonstration is rec-

ognized as an essential part of the program of every meeting. The county medical societies of the United States, one thousand or more in number, constitute the greatest system of graduate medical education in the nation; in fact, it may be truthfully said that it is the greatest graduate school in any line of instruction.

One of the most valuable features of the graduate education courses of the county medical society is the instruction given by its members one to another by informal conversation. This fact was recognized in the earliest years of the State Society, for the minutes of the meeting of November 9, 1773, contain the following record:

"The members present entered as usual into a free, social, medical conversation, and found a peculiar satisfaction in communicating to each other some cases and observation which have occurred in the course of their practice since the last general meeting."

Again on May 10, 1774, the minutes read:

"The members find so much of the agreeable and improving in it (medical conversation) that they determine for the future to devote as much of the day to that purpose as can be spared from other business."

Impromptu discussions by the students in their moments of relaxation is recognized as the most valuable opportunity of every college and university. It is equally true of every county society today.

A. M. A. House of Delegates

The special meeting of the House of Delegates of the American Medical Association held on February 15 and 16 accomplished a definite piece of work. The Friday sessions enabled every delegate to express the opinions of his constituents. Some said they were opposed to all forms of health insurance; while others said that the people are already prepared for essential changes in the practice of medicine, and that physicians will be compelled to give them what they want.

The points of the debate were considered by the Reference Committee during Friday night and were adopted unanimously on Saturday. It is most encouraging that the delegates were of one mind regarding the judgment of the House.

The House reaffirmed its encouragement of local medical organizations to provide adequate medical service by voluntary budgeting to meet the costs of illness. It also suggested that the A. M. A. prepare skeletal plans for medical services adapted to the needs of populations of various types and report them at its June meeting. This is real progress in the solution of the question of future medical practice. (See Dr. Hagerty's summary on page 157.)

Consult Your Medical Society

A decade or two ago, the welfare organizations started a campaign whose slogan was *"consult your doctor"*. The instructions for "first aid" always began with the trite direction, "send for a doctor"—which was excellent advice, but unnecessary, for in an accident or sudden pain, the people would send for half a dozen doctors.

The County Medical Society as the *family doctor to the community* is a new conception which the public has not yet grasped. It is a fact that few persons, even among the educated class, think of the County Medical Society when a public health movement is under consideration. The people need to be educated regarding the leadership of the Medical Society in community health problems. But if the Society is to acquire this reputation, its leaders must be prepared to instruct the health organizations to seek the advice of the County Medical Society.

The precept, *"Consult your doctor"*, needs to be supplemented with the slogan "Consult your County Medical Society".

The Class in Public Speaking

Doctors are realizing the necessity of making contacts with lay health organizations, such as parent-teachers associations, anti-tuberculosis societies, and public health nursing organizations. Every physician approves the plan that health lectures should be given to lay audiences by physicians representing county medical societies, providing he himself does not have to give the talks.

The unwillingness of physicians to give health addresses may be a hold-over of their schoolboy objection to "speaking pieces" and "writing compositions", and yet in the smoking room they express themselves as spontaneously and eloquently as boys on the playground. It may be too that the doctor has acquired an inferiority complex through hearing dull speeches and discussions in county societies.

The ability to talk before an audience pleasingly and effectively may be easily acquired, as is demonstrated in evening classes conducted by Y. M. C. A.'s and other civic organizations. The system consists in the elimination of mannerisms of speech and action of each speaker, and the development of simple rules of logic of thought and forms of expression. The student learns by actually speaking. His associates are his critics, and the watch of the instructor is the indicator of the end of the few minutes assigned to him for developing his point.

The class instruction is a game in which all win the prize of readiness of thought and expression while standing before an audience. It is a fact that the graduate of the class retains his zest for public speaking and is ready to practice it when the occasion arises. The instruction will benefit not only the lay organizations which the doctor addresses, but also his county society.

The project of a class in public speaking for physicians is comparatively new in medical societies; but its popularity and usefulness are abundantly demonstrated by experience.

Advertising Health

The efficiency of medical services depends not only upon the ability and preparedness of the physicians, but also upon the desire of the people to accept medical services and to make use of them to the fullest extent.

A person who is in pain or is incapacitated by sickness is anxious to call a doctor and follow his advice.

When an epidemic is raging, the people seek the advice of physicians as to the means of preventing the disease. They magnify every suggestive symptom, and rush to the doctor to find out whether or not they have already caught the disease. But when the immediate threat has passed, they lose their interest in diagnosis and prevention.

A chronic disease comes on insidiously, and the patients often delay consulting a doctor because they fear they will be told that they already have the condition which they dread.

A half century ago the vendors of patent medicines appealed to the emotion of fear by means of almanacs listing sets of symptoms which every person sometimes has and for which the advertised medicine was suggested as a sure preventive or cure. That tired feeling, the familiar backache, and the annoying loss of appetite, all indicated kidney disease, for which "nature" has already provided a remedy at a dollar a bottle. The people were "educated" to buy the quack medicine rather than to seek the advice of a physician. The studies of the Committee on the Costs of Medical Care demonstrated that people spend for proprietory remedies almost as much as they do for the advice of physicians.

The appeal to a fear of disease has rarely had desirable effects on public health. Modern health publicity minimizes thoughts of disease and replaces them with ideas of well-being. This is the effective appeal of the health columns of magazines, and of lay organizations such as anti-tuberculosis leagues and parent-teachers associations. Advertising health will benefit both the physician himself and the people.

The Parent-Teacher Association and the Doctor

The relation of the medical profession of New Jersey to the Public Health Hour project is like that of the young physician sitting in his well-equipped office waiting for patients to come. A thousand physicians have signed up to give vaccinations and immunizations in their offices at reduced prices, but are disappointed with the small number of children who are brought to them. This situation was the subject of some concern at the Conference of Health Officers on February 15 in the State House in Trenton.

There was no criticism of the physicians, but the point was brought out that the habits and customs of the people were hard to change. Parents have been accustomed to having the public health nurses and the Parent-Teachers Associations conduct free clinics, put on campaigns of publicity, and provide transportation to the places of immunization. The clinic is a social function to both its promotors and the parents. A large number of children were immunized as the result of the organized campaigns; the smaller numbers immunized through the unaided efforts of the doctors alone is interpreted as a failure of the project and the inefficiency of the plan of the Medical Society.

An element of incompleteness in the plan of the physicians is that both mass advertising and personal solicitation are lacking. When no danger of contracting diphtheria is immediately present, the people are apathetic and are aroused only by some methods of personal solicitation. The problem of the doctors is to devise a method of implanting in parents a *desire* to bring their children to the doctors' offices. The people will not come unless the Parent-Teachers Associations—the leaders in the campaign for immunization—concentrate their efforts on the doctor's office instead of the clinic.

The National Congress of Parent-Teachers Associations has put forth a pamphlet containing its plan of action for 1935, in which it states positively that the Association favors the plan that the immunizations shall be done by private physicians in their offices. The attitudes of both the Parent-Teachers Associations and The Medical Society of New Jersey opens the way to success in the plan of the physicians.

When one considers the immense amount of time and effort, and the number of persons engaged in promoting an immunizing clinic, it is reasonable to suppose that an equally great effort to bring the children individually to the doctors' offices will produce results equally as good as those of the mass clinic. Securing this coöperation is the opportunity of the Public Health Committees of the Medical Societies.

Industry in Medical Economics

In this issue of The Journal, page 148, there appears an article by Dr. Francis H. Glazebrook under the title "Industry's Contribution to the Cost of Medical Care". Every member of the Society should read this carefully. It contains suggestions which merit thought, and many of these suggestions will likely be incorporated into the practice of medicine of the future.

The County Medical Society must become a real service organization, preferably voluntarily and as a natural development in the evolution of medical practice.

Organized effort is the keynote of today and the future. Dr. Glazebrook, out of a full experience in private practice as an individual and as an executive of organized service, is well qualified to contribute understandingly and authoritatively to medical practice under the changing conditions with which we are now faced.

No one man can prescribe finally for this ailing world, but Dr. Glazebrook has made a worthy contribution.

LeRoy A. Wilkes, M.D.,
Executive Secretary.

ORIGINAL ARTICLES

MENINGITIS FROM THE PETROUS APEX AND THE SPHENOIDAL BASIS

By WELLS P. EAGLETON, M.D., Newark, N. J.

Summary of paper presented before The Medical Society of New Jersey, Section on Eye, Ear, Nose and Throat, Atlantic City, N. J., June 6, 1934

The theory of the specificity of function of a tissue, depending upon the embryonic anlage from which its cells evolve, is of surgical value in an understanding of pyogenic lesions of the skull, as it furnishes an explanation for the variations in tissue reactions to infection of bones of unlike embryonic origin. Thus a pyogenic inflammation of a petrous apex or the sphenoidal basis (a) runs a distinctive course, and (b) requires a different surgical viewpoint than infections of an adjacent cranial bone, such as mastoiditis, nasal sinusitis, or osteomyelitis of the cranial vault.

Petro-apicitis is frequently an unrecognized cause of meningitis. In the vast majority of cases, it is a true osteomyelitis. Petro-apicitis represents a different pathological and surgical entity from the recognized forms of mastoiditis, with which apiceal suppuration is usually, but not invariably, associated, occurring as it does in a generically different type of bone.

Infections within a petrous apex have a much greater tendency to spontaneous cure, i. e., without the opening of the infected area, than has the associated mastoid suppuration, because in apiceal suppuration the infection is influenced by the presence of red bone marrow.

CLINICAL CLASSIFICATION OF APICEAL INFECTION

I propose a *clinical classification,* based on my experience with forty-two cases of petro-apicitis and twenty-four cases of the sphenoidal basis, as follows:

1. Reactive and reparative osteitis
2. Non-suppurative congestive cases—symptoms due to venous stasis
3. Chronic bone sepsis cases (without macroscopical pus)
4. Abscess of apex:
   a. Without a tract
   b. With a tract
5. Acute septicemia cases, associated with a continuous positive blood culture and meningitis

INTRA-MEATAL TYPE OF FACIAL PARALYSIS

There occurs a *specific type of facial paralysis* in petro-apicitis which is seen in no other process. This "suspicion of a facial" (an intrameatal type of facial paresis) is transient in duration and limited in extent. It is characterized by the partial non-closure of the lower lid during sleep, although the ability, spontaneously, to close the lid completely is not lost.

Meningitis from suppuration of the apex is at first limited to the cistern, (a) covering the floor of the middle fossa, or (b) mesial to the internal auditory meatus of the posterior fossa.

INFECTION OF THE SPHENOIDAL BASIS

The pattern of blood supply within the red bone marrow accounts for the unique reparative and specific protective properties of the sphenoidal basis, which is also possessed, but to a lesser extent, by the petrous apices. It also explains the rarity of small sequestra in pyogenic lesions of an apex or of the sphenoidal basis.

A symptomless infection of the sphenoidal basis is a frequent, but generally overlooked, cause of meningitis, especially of the pneumococcic type. In pneumococcus Type II meningitis, I have cured cases by simply draining the sphenoidal sinus and the administration of serum.

CONTROL OF INFECTION BY METAPLASTIC RECONVERSION FROM YELLOW (ACELLULAR) FAT MARROW INTO RED (CELLULAR) BONE MARROW

During infancy and childhood, all the bones of the torso and extremities are filled with red (cellular) bone marrow containing no fat. However, none of the cranial bones, with the exception of the sphenoid, the occipital, and the two petrous apices (which form the pri-

mordial basis of the skull) contain red bone marrow; although the bones of the tympano-antral area of the nasal accessory cavities which increase in size by pneumatization are, at birth, filled with yellow, fat, marrow. The red (cellular) marrow at osseous maturity, subsequently, is converted into yellow acellular fat. This metamorphosis from red into yellow fat marrow occurs in all red (cellular) marrow-containing bones, with the exception of the sphenoid, the segmental portion of the occipital, the vertebrae, the ribs, and the os innominatum, whose spongeous tissue has a preponderance of red (cellular) bone marrow throughout life.

However, at any time, if an irritant, notably infection or cancer, enters, or even indirectly affects a marrow-containing bone, its yellow (acellular) fat marrow may become reconverted into red (cellular) marrow. This rapid metaplastic reconversion from yellow (acellular) fat marrow to its original state of red (cellular) marrow is, I believe, an evidence of the tissue mechanism which red-marrow-containing bones possess for the local control of infection.

Metaplastic reconversion from pneumatic air-filled cells to its original red bone marrow state within an apex accounts for the infrequency of apiceal abscess.

Primarily, the petrous apex is a red (cellular) marrow-containing bone, its red marrow being converted into fat or replaced by air-filled cells early in life. It does not combat infection simply by pouring forth round polymorphonuclear cells brought to it by the circulation, as is the reaction of the mastoid to suppuration; but on the approach of infection, the pneumatic spaces within the apex may return to their original bone marrow state. Thus it may become the seat of a unique physiological metamorphosis, to which attention has not been previously directed. This phenomenon I have observed in at least two cases, as demonstrated at post-mortem.

TREATMENT OF MENINGITIS FROM THE PETROUS APEX AND SPHENOIDAL BASIS

If we are to be successful in the treatment of meningitis, we must abandon many of our preconceptions for, in the past, all surgical treatment has been based too much on the principle of drainage of the entire arachnoid circulation, which is impossible.

In my opinion, operation on the meninges, if preceded by ligation of the common carotid artery, gives a higher percentage of recoveries than otherwise, because carotid ligation relieves venous congestion, which post-mortems show to be invariably present in all cases of meningitis.

In the surgical treatment of meningitis, it is of paramount importance that the surgeon should early diagnose and thoroughly drain the primary focus of infection in the petrous apex or in the sphenoid—lesions that are curable—for eradication of a primary focus in a bone, associated with the evacuation of an adjacent localized collection of infected cerebro-spinal fluid, allows the protective and reparative mechanism of the meninges an opportunity to act. This procedure has been followed by a larger percentage of recoveries than any other method of treatment, either surgical or medicinal.

EVALUATION OF THE VARIOUS PROCEDURES OF DIPHTHERIA IMMUNIZATION—A RESUME OF THEIR ADVANTAGES AND DISADVANTAGES

By H. Louis Fuerstman, M.D.,
Department of Health Education and Service, Board of Education, Newark, N. J.

Read before the Section on Pediatrics of The Medical Society of New Jersey, at the Annual Meeting in Atlantic City on June 7, 1934

One of the most outstanding contributions to the progress of preventive medicine is active immunization against diphtheria. Ever since Ehrlich's announcement of his theory on immunity, and Behring's introduction of toxin-antitoxin (5L+ dose) for diphtheria prophylaxis, several modifications of the diphtheria antigen and various procedures for conveying active and lasting immunity have been rapidly evolved. The progress achieved within the

past two decades, chiefly through intensive experimental and clinical research, has been marked by numerously interesting immunological and epidemiological observations. Specific measures for the standardization of the antigenic potency by biological tests and the flocculation reaction have been designed and approved. Clinical methods for the quantitative estimation of antitoxin production by titration of blood serum and the Schick reaction test have been devised and adopted for universal application.

As early as 1917, William Park and his coworkers immunized children with toxin-antitoxin mixtures containing three lethal guinea-pig doses of toxin, gradually diluting the toxin because of frequent and severe reactions, until they found that as little as one-tenth lethal dose (1/30 original strength) gave equally efficient and lasting immunity without the objectionable reactions. The preparation and testing of the mixtures, according to the standard of the United States Public Health Service, required a great deal of care to obtain an accurate balance between diphtheria toxin and antitoxin to insure both immunizing efficiency and freedom from toxic reactions. Dr. Park has pointed out that a maximum potency consistent with safety was obtained if the toxicity of the human dose was sufficient to kill a guinea-pig of 250 gms. within a period of four weeks. Park and Zingher were also the first to study the effect of active immunization by introducing the Schick retest and the control test of heated toxin four to six months following the administration of toxin-antitoxin to note the change in reaction.

In 1923, approximately ten years after the introduction of toxin-antitoxin, it was reported by Ramon, of the Pasteur Institute, that diphtheria toxin, rendered completely non-toxic both by the chemical action of formalin, suggested by Glenny, and the additional exposure to heat, did not only possess greater antigenic power than could be attained with the mixtures, but obviated the technical difficulty experienced with their neutralization in order to obtain an accurate working formula. This modified toxin or anatoxine, better known as toxoid, diluted in normal salt solution instead of antitoxin, proved to possess greater stability and higher immunizing value and none of the danger of serum sensitization. The antigenic efficiency of the human dose was sufficiently potent to protect a high percentage of guinea-pigs against five minimal lethal doses (M. L. D), while its durability was assured for at least eighteen months, instead of six months, under variable conditions of temperature. It was, therefore, immediately adopted as an improved immunizing agent, and the use of toxin-antitoxin was rapidly supplanted by toxoid in the countries of France, England and Canada.

In other countries including the United States, the Park modification, O.1L plus dose of toxin-antitoxin was exclusively employed without the untoward effects experienced with the stronger mixtures. A high percentage of immunity from the mixtures has not, however, been obtained regularly by all workers. The results frequently varied between fifty and eighty-five per cent, depending upon the degree of neutralization, the dating of the product, the care of preservation and environmental conditions. The added objection, namely the possible sensitization to horse serum, was readily removed by substituting goat and sheep antitoxin. Its freedom from severe reactions and its use as a substitute for the Schick test, often referred to as the Park test, were considered of particular advantage in mass immunization. The accuracy of the Park test depended largely upon proper technic, correct interpretation, and maximum potency. This test in our experience was not found as practical nor so adequate as the Schick test accompanied by control.

In the City of Newark during the past ten years, the toxin-antitoxin mixtures (Park formula) have been employed both in school and pre-school children with great satisfaction and without a single mishap—three doses of 1 cc. each, given subcutaneously at weekly intervals, produced an average of 85 per cent successful immunity within a period of three to four months. As soon as the goat serum variety was made available it was promptly and exclusively employed. Written parental consent was required before any child was inoculated. Approximately 50 per cent of pre-school and

about 65 per cent of school children have been protected through the use of toxin-antitoxin. From personal knowledge the immunity thus produced was found to extend over a period of five years. When immunization was concentrated on school children only, practically no effect on diphtheria incidence followed, but as soon as the campaign was extended to the pre-school child, a marked decrease both in the incidence and death rate was at once apparent. In 1933, Newark has experienced an unprecedentedly low prevalence and mortality as a result of immunization—the total cases numbering 22 with 1 death as contrasted with previous annual averages of 1000 cases and 65 deaths. In New Jersey the number of cases of diphtheria reported during 1933 was 1035 and the number recorded deaths from this cause was 52.

While adequate results were uniformly obtained in the child population of the larger cities, the response elicited in certain areas, particularly rural sections, appeared to be less favorable. Immunization of adults, based on our results, has also proved unsatisfactory with toxin-antitoxin, since at least 50 per cent failed with three doses, besides having frequently suffered from pronounced local and constitutional reactions. Notwithstanding these undesirable effects, five doses for adults have been recommended, producing about 82 per cent successful immunity as shown by Dick and Dick.

Immunization with the Ramon toxoid, on the other hand, according to the author's experience with two 1 cc. doses in children and three 1 cc. doses in adults, at intervals of three weeks, was found decidedly superior to immunization with the best standardized toxin-antitoxin, establishing a record of 93 per cent successful results. The better and more rapid immunizing effect was attributed to its higher potency and greater stability. Immunization with similar doses of toxoid given at shorter intervals, as suggested in a preliminary communication, was found much less efficient. Ramon later proved that generally a better result was obtained when a longer interval between doses was allowed. Ramon also holds that toxoids are of further advantage since antitoxin for prophylaxis can be given between doses without interfering with the development of active immunization. Its only disadvantage noted, particularly in older children and adults, was the annoying allergic reaction, which full doses sometimes produced, due to the protein constituents of the broth, and the metabolic products of bacterial growth. This obstacle, however, was readily averted by a preliminary intradermal toxoid reaction test—a dilution of toxoid 1 to 20 in saline, by which all hypersensitive individuals to diphtheria proteins were pre-determined. In young children, under three years of age, reactions to the toxoid test were so seldom observed that the test came to be entirely omitted. The writer adopted the toxoids for children of pre-school age, but continued the use of toxin-antitoxin in school children, especially in those over 8 years of age. Undesirable local and general reactions in older children and adults were obviated by the preliminary toxoid test. Positive toxoid reactors presenting an area of redness over 1 cm. within 48 hours as indicative of supersensitiveness to non-specific proteins were given toxoid in small divided doses and appeared to respond more readily to immunization than persons not sensitive to diphtheria proteins.

In 1926 Glenny and his associates announced that the efficiency of the antigenic value of toxoid was considerably increased by the addition of ½ per cent alum (aluminum potassium sulphate) which partially precipitated the toxoid causing slower absorption and more gradual elimination of the antigen, resulting in prolonged stimulation of the tissues to antitoxin formation. Three injections of ½ cc. each of partially precipitated toxoid, given to children at weekly intervals, rendered 98 per cent immune according to Park's investigation. Fewer reactions were encountered when the injections were made intramuscularly. In 1932 Havens, of the Department of Health of the State of Alabama, following the method of Glenny, described the complete precipitation of toxoid by the use of larger amounts of alum 2-10 per cent, which was found to possess still greater immunizing power. According to results claimed by his associates, Graham et al, a single dose of completely precipitated toxoid conferred immunity in 92 per cent of children within two to four months,

with none of the severe reactions usually observed with simple toxoid. Recent research indicates that two doses, 1 cc. each administered seven days apart, produce immunity in practically 100 per cent. Precipitated toxoid, like ordinary toxoid, is non-toxic, non-sensitizing, and unaffected by temperature changes, but unlike simple toxoid is insoluble, and consequently less rapdily absorbed, and more slowly eliminated. Its superior antigenic action is explained on the basis of its relative insolubility and prolonged stimulation producing a higher antitoxin-titre and, therefore, better protection.

According to the standard of the National Institute of Health, the antigenic efficiency of the human dose of alum precipitated toxoid administered to guinea-pigs must produce within six weeks at least two units of antitoxin per cc. of guinea-pig blood. To safeguard against variation in potency of commercial products, the toxoid preparations must conform to the following additional requirements, namely:

1. The original toxin must not contain less than 5 L + dose or 400 M.L.D. per cc.
2. The human dose of toxoid must protect not less than 80 per cent of guinea-pigs for 10 days against 5 M.L.D.

These specifications correspond conservatively to at least five antigenic units. Dr. Park holds that alum toxoid should have at least 15 flocculating units by the Ramon test, although favorable results with preparations averaging 5 to 10 units have been obtained. Recent investigation tends to indicate that the antigenic efficiency of toxoid does not depend so much upon the greater number of antigenic or flocculating units as upon the guinea-pig protection test. In other words, there is no direct relation between the amount of antigenic units administered and the immunity produced. Welton further demonstrated by laboratory tests on guinea-pigs that not only is alum toxoid more effective than ordinary toxoid, but that divided doses of either toxoid of lesser quantity are more effective than single doses of larger quantity.

The advantage of the single injection in diphtheria prevention is obvious, nevertheless one feels reluctant to change from older methods until sufficient evidence of the efficacy from the antigenic action of one dose is definitely established, and its relative freedom from discomfort absolutely assured, in order that it may receive no setback from the general public.

To ascertain the efficacy of a single dose of alum toxoid, as well as to experience the frequency of toxoid reactions in children of school age, a group of 100 children between the ages of 4 and 7 years was selected on the basis of a positive Schick reaction. To avoid annoying local reactions, the toxoid reaction test was employed together with the initial Schick test in place of the control. Those found susceptible to diphtheria and non-sensitive to toxoid were given a single 1 cc. dose of alum toxoid by subcutaneous injection, which was followed by little or no reaction. Only 5 per cent in this group exhibited positive reactions to the toxoid test. Schick retesting together with control was performed within two to four months, and the immunity obtained proved successful in 93 per cent of the cases. The toxoid employed was developed, according to the principles reported by Ramon, from a potent diphtheria toxin to which .4 per cent formalin has been added and placed in an incubator at 38° C. for a period of one month until detoxification was complete. Following the suggestion of Havens, 1.5 per cent alum was then added until complete precipitation of the toxoid was produced. Its antigenic action was controlled by the tests officially recognized by the National Institute of Health.

The innunction of diphtheria toxoid in lanolin by the simple percutaneous method of Loewenstein, consisting of 5 massages at weekly intervals rendered 70 per cent immune after a period of 4 to 6 months, according to authentic reports, but the immunity following this method is apparently of short duration. Attempts at scarlet fever immunization by this method with Dick toxin have met with even greater failure.

Again we are reminded of the importance of the final Schick test to determine successful immunity following immunization, regardless of age or method, since some children may

remain susceptible, and require further treatment to complete the immunity. It is advisable to use control Schick in all children after the fifth year, in order to differentiate true from pseudoreactions, which are found with frequency in older children particularly after immunization. A stabilized Schick toxin suitable for private practice is obtainable in a 2 per cent peptone diluent which retains its potency for a period of one year. It is deemed essential to employ a control test of heated toxin in peptone solution for the purpose of comparison with Schick peptone reactions.

The following procedure is suggested for immunization with alum toxoid without employing the toxoid tests: Children under three years whose reactions to toxoid are negligible, are given one single dose of 1 cc.; school children and adults, who are apt to give more frequent and more severe toxoid reactions, are given ¼ cc. for the first dose. In the absence of a marked reaction after an interval of one week, a final injection of 1 cc. is given. If a severe reaction occurs, the dose should not be increased, but continued at intervals of two weeks until 3 doses are given.

The adoption of the single dose of alum toxoid for immunization in pre-school children, especially under three years, is strongly advocated, but for school children after the eighth year, unless the toxoid reactors are predetermined in the manner described, the use of toxin-antitoxin is preferable. Improved alum toxoid, refined and concentrated, with increased antigenic quality and diminished proteins, are now available. It is safe to predict that with the protein substances almost entirely eliminated, the alum precipitated toxoid is destined to become the method of choice.

RECOMMENDATIONS

1. Evidence of active diphtheria immunization or naturally acquired immunity should be made compulsory for admission to public and private schools, and child-caring homes and institutions.

2. Parents should be forewarned and urged to have their infants immunized against diphtheria at the most suitable and most desirable age, which is during the second six months of its life. Special emphasis should be placed upon the strong susceptibility to diphtheria and the high mortality from this cause among pre-school children.

3. Haven's toxoid, particularly in the young, should be the method of choice, since only one or two doses are required to produce successful immunity with little or no reaction.

4. Immunization should never be considered complete without a follow-up Schick test regardless of the method employed, especially in strictly rural communities where the natural processes of immunization are frequently lacking. The control Schick test should be used in all children after the fifth year.

5. Incomplete immunization following toxin-antitoxin should be supplemented by alum toxoid except in the presence of marked pseudoreactions.

CONCLUSIONS

1. The highest degree of immunity for personal prophylaxis against diphtheria can be safely and readily obtained by alum toxoid with practically no reaction. The findings presented justify the conclusion that a single dose of alum toxoid is as effective as two doses of ordinary toxoid and more effective than three doses of toxin-antitoxin.

2. In no other group is active diphtheria immunization of greater moment than in the pre-school group, which can be reached by none better than the family physician.

3. The successful nation-wide and general control of diphtheria morbidity and mortality can be primarily ascribed to the enthusiastic campaigns sponsored by educational and public health authorities, the active coöperation of the medical profession, and the widespread application of present-day accepted methods of diphtheria prevention.

4. Complete eradication of the disease, the ultimate objective of diphtheria prevention, can be effected *only* by persistent and intensive immunization, widely and evenly distributed, and efficiently and permanently sustained.

5. The recent tremendous decline in diphtheria is not a cyclic phenomenon, not the experience of one city, but of many cities, in different countries, always associated with active diphtheria immunization and proportionate to the extent of its use.

CONTAGIOUSNESS OF ACUTE RESPIRATORY INFECTIONS IN CHILDREN FROM A RHINOLOGICAL POINT OF VIEW

By William J. Greenfield, M.D., Hackensack, N. J.

Abstract of a paper presented at the New Jersey State Medical Meeting before the Pediatric Section, at Atlantic City, N. J., June 7, 1934.

The object of this paper is to determine where we stand in regard to the causal factors of the minor respiratory infections.

Extensive public health surveys have been made, covering institutional life, small communities, cities and states. They all call our attention to the marked amount of disability which follows in the wake of the ordinary cold and other allied respiratory infections.

Zinsser emphasizes the importance in the future of paying more particular attention to the study of the *atypical* manifestations of the more common contagious diseases, for they are prevalent and may represent one of the causes for our common colds.

THE COMMON COLD

The common cold represents the largest groups of our respiratory diseases, and its etiology is largely unknown, although a submicroscopic virus is suspected. It is a condition that is usually considered so trifling that vigorous individuals do not permit the disease to hamper their daily pursuits. As a consequence, promiscuous associations continue without precautions. This results in colds going through whole families, schools, and business groups and rapidly becoming scattered in many different small epidemics throughout the communities.

Collins in his summary, states that out of a total of 8,758 white families in 130 localities in eighteen states which were observed for illness for a period of twelve consecutive months between February, 1928, and June, 1931, that the minor respiratory conditions were the most frequent causes for illness, whether one considered the total rate, rate for disability, or rate for bed cases. In this survey, each family was visited from two to four months to obtain the sickness record. This is found to be true in most studies that have been made.

The causes of our common, so-called noncontagious, respiratory infections may be classified as *direct*, and *indirect*. By direct causes I mean those illnesses that are due to a definite infectious organism which can be isolated by the laboratory methods. Indirect or predisposing factors are those that make people susceptible to repeated attacks.

The causes of our minor respiratory disturbances fall practically into four groups; 1st, bacteria; 2nd, filterable viruses; 3rd, atmospheric changes; and 4th, allergic manifestations.

The usual bacteria considered as the primary causes of colds are: hemolytic and non-hemolytic streptococcus, pneumococcus, Pfeiffer's bacillus, micrococcus catarrhalis, and staphylococcus. These organisms are frequently present in the tonsils, naso-pharynx, and sinuses as a latent force, waiting to be stirred into action by some predisposing cause in the individual. These predisposing causes may be an attack of an ordinary cold due to filterable viruses, or extreme exposure of the individual to atmospheric cold. Streptococcus hemolyticus is the chief organism that seems to vary in its virulence, and is the most frequent found present in acute infections of the nose and throat.

Gordon recognizes three main groups as streptococcus pyogenes or hemolyticus; streptococcus salivarious or viridans; and streptococcus fecalis or enterococcus. The streptococcus hemolytic organism is further classified into first, the beta type; the alpha prime type; the alpha type; and the gamma type. The last three types are not considered virulently pathogenic for man. Bloomfield in a study of a thousand cultures of hemolytic streptococcus was unable to recover from a case of tonsilitis, erysipelas, scarlet fever, and other acute streptococcus infections, a strain which did not have typical and undoubted beta types of characteristics. The hemolytic activity of this organism is undoubtedly an indicator of its pathogenicity. Holman classifies streptococci

into two main groups, the hemolytic and the viridans, with five strains in each group.

FILTERABLE VIRUSES

The unfound cause of the common cold is still rightfully attracting considerable attention in research. The reports of Dochez, Shibley, and Mills are the most recent reliable evidences we have. They found filterable viruses transmitted from man to chimpanzee by means of Berkefeld filtrates of nasal washings. The most important observation was the fact that the inflammation produced by the filterable viruses stimulated into great activity the organisms already present in the respiratory flora. They also state that the contagious cold was caused by an invisible, filterable, and uncultivatable agent, which in all likelihood belongs to the group of so-called submicroscopic viruses. There is now some experimental evidence that this virus may be a mutable or dissociated form of streptococcus.

ATMOSPHERIC CHANGES

The influence of atmospheric changes on the respiratory mucous membranes has been exceptionally well described by Wells in his book on "The Common Head Cold". He describes Lode's experiment with animals infected with pneumococcus where the mortality was 85 per cent for animals exposed to the cold, and only 12 per cent in those not exposed. He recites the well-known fact that prolonged exposure of the body to cold damp air, particularly the feet, causes a vasomotor congestion of the erectile tissue and mucous membrane in the nose. This attendant nasal obstruction is usually called a cold by the sufferer and clears up in 24 to 48 hours if uncomplicated by infection. Should a virulent strain of the pathogenic bacteria previously mentioned be present, the usual cold syndrome is very apt to occur.

ALLERGY

Vasomotor rhinitis is often misinterpreted as a cold both by patient and doctor. It is neither due to local nasal organisms or to atmospheric exposure. It can be completely controlled because its causal factors are known. These causal factors are chiefly allergy, general vascular disturbances particularly hypertension, toxins from general infections such as tularemia, etc., and neurogenic causes. If the causes are not removed, the prolonged congestion and turgescence of the erectile tissues in the nose cause a gradual loss of the elastic structures in the membrane with a resultant hyperplastic degenerative change with or without polypoid formation. Both the temporary and the chronic congestive changes represent fertile fields for bacteria to become virulent and propagate rapidly with subsequent acute or chronic head cold syndromes. This then may be a direct cause of head colds but more likely an excellent predisposing cause.

PREDISPOSING CAUSES

Indirect or predisposing causes of acute respiratory infections (so-called non-contagious) are chronic paranasal sinus disease, chronic or persistent vasomotor rhinitis, tonsils and adenoids, dental caries, atmospheric and physical changes of temperature; and a constitutional condition called *exudative diathesis*. It is not necessary more than merely to mention these conditions before this body of medical men. You are all sufficiently aware of the symptoms and signs of these predisposing pathological entities to refer them to the rhino-laryngologist, the allergist, or the dentist, if you cannot properly eradicate the disease yourself.

Exposure to atmospheric changes in temperature is of only secondary importance. If the body is free from acute respiratory disease-producing bacteria and chronic thickened inflammatory membranous changes, then even prolonged exposures to cold will not produce the usual cold syndrome reactions. Perry, Stephanson and others in their Arctic exploring expeditions all state that no one in their party ever became ill with a cold unless it followed recent opening of packages packed at home or followed a visit of strangers, frequently, a distant tribe of Eskimos.

MECHANICAL TRANSMISSION

If the direct causal factors of colds are bacteria or filterable viruses exclusively, then the transmission of colds is explainable. When

conveyed from one to another it is a simple and mechanical proposition. It can be avoided by proper hygienic precautions. If the person harbors in his own body his own cold organisms, then it is understood that the removal of these factors are necessary to reduce his susceptibility.

The transmission and control of the respiratory infections by mechanical means was interestingly brought out by Abranson and Barenberg. In a home of Hebrew infants, two wards were selected for study; a protected ward and a controlled ward. All precautions were rigidly observed, such as nursing technic, etc. Masks were changed daily, hands were thoroughly scrubbed and immersed in mercuric bichloride each time; new paper towels used each time. No fondling or petting of the children was allowed. Nurses with sore throats were not allowed to care for the children. Infants were examined only when necessary. Immediate segregation was enforced with any rise in temperature. No dusting or sweeping was allowed. Beds were located three feet apart and children were all under one year of age. Under these circumstances they found that infections were only 10 per cent less in the protected ward. The investigators found that the nurses were the chief rule breakers. For instance, a nurse in the protected ward remained on duty with a sore throat, resulting in a mild epidemic. Another nurse with tonsilitis caused a marked epidemic in all infants in two or three days in spite of all precautions. They also concluded that it is increasingly difficult to prevent contagion as children grow older because the contacts were greater. They found that infections were 50 per cent greater among crib than bassinet children. They concluded that aseptic nursing was of no value in preventing the spread of varicella (chicken pox). A case of chicken pox occurred exactly two weeks after regular visitors' day. One of the mothers had been in contact with a case of chicken pox just prior to her visit to the ward. This illustrates the difficulty of controlling the transmission of our common acute non-contagious infections.

Zinsser states that in several small groups examined by him it was possible to show that during an existence of an epidemic of colds, at least 25 per cent of the group became carriers of virulent members of streptococcus and pneumococcus groups alone.

SCHOOL CHILDREN

There is no group in our whole population which are so universally susceptible to diseases conveyed by respiratory secretions as school children. Although carelessness of contact is the outstanding feature, yet their resistance has not been fortified by previous attacks of these diseases. Natural resistance may be stimulated by previous generalized exposure and infection. A general susceptibility may exist at birth and become a definite immunity in adults. Consequently, epidemic outbreaks of many diseases are epidemic among children only such as scarlet fever, German measles, poliomyelitis, chicken pox, mumps, etc. These infections, often regarded as infantile diseases, are probably not so because of the age factor alone. It is more likely that the first exposure occurred long before adolescence and consequently, there will be a progressive decrease of the susceptibility with each age group. Influenza becomes pandemic because general susceptibility is the rule, and immunity does not persist for any considerable length of time. It is quite evident that there are many mild immunizing attacks of poliomyelitis which cannot be recognized by present methods. This accounts for the relative immunity of adults to this disease and the irregularity with which it is scattered through the communities in epidemics. Sporadic cases of meningitis and, to some extent, of scarlet fever, may be accounted for in the same way.

TESTS FOR SUSCEPTIBILITY

Due to advancements in medical science, methods are now available for determining in many diseases the specific susceptibility of individuals. Here we have a weapon we can wield to protect the susceptible person and dismiss the one found resistant to the disease. The Schick reaction determines rapidly and with reasonable reliability the individual's ability to combat diphtheria. The Dick test for scarlet fever will give us similar help. This factor helps us control these diseases. Unfortunately similar tests for bacteria associated

with acute respiratory infections have not been discovered. Wholesale prophylactic innoculation and vaccination have been particularly successful in cholera plague and dysentery. It is not successful in pneumonia or meningitis. It has offered us very little help in the acute so-called non-contagious respiratory infections.

Zinsser states that every species of animal has its definite level of resistance to any infectious agent, and this explains in part the variations and susceptibility of the human race to different infectious agents. Lowered resistance to any specific new infection manifests itself when newly introduced into groups of people never before exposed, such as Indians, Eskimos of the North, and Sea Islanders of the South. In these instances, they become epidemic wtih a virulency far more severe than observed in civilized countries. No disease can become epidemic unless a relatively high degree of susceptibility to the infectious agent exists. Sporadic cases of infection to which individuals have a relatively high resistance may occur, but this would depend on a special condition, such as direct contact with an unusually large dose, or a lowered resistance exceptionally depressed by malnutrition, exposure, or coincident illness.

Other forms of artificially raising the resistance of the individuals, such as ultra-violet radiation and special vitamin medication, have not been universally successful.

COMPLICATIONS

Complications of the ordinary respiratory diseases, excluding contagious diseases, have a wide range from mild attacks of sinus disturbances or otitis media to death from pneumonia or septicemia or both. A severe disturbance of malnutrition in infants may be started by a simple acute cold and go on to marasmus, persistent diarrhea and death. Older children, but not excluding infants, frequently have a chronic sinusitis instituted by a simple cold, thus establishing the "vicious circle".

The "vicious circle" is the establishment by an acute cold in the paranasal sinuses of a chronic active inflammatory condition whose presence carries latent pathogenic organisms which, with the slightest lowering of resistance, cause the unstable membrane to flare up acutely into a typical common cold syndrome. These children present themselves with all sorts of respiratory and general complaints which on investigation reveal marked hyperplastic changes in the lining membrane of the sinuses with or without purulent secretion.

Other frequent well-known complications follow these infections and they are: adenitis, bronchitis, laryngitis, pneumonia, and pyuria.

Another interesting complication not ordinarily looked for is that reported by Ballinger who concludes that a bacteriemia secondary to an acute hemolytic streptococcus throat infection is probably of common occurrence and possibly is the usual accompaniment of this type of infection. The bacteriemia is transient and evanescent in character in the vast majority of cases, and is not accompanied by the usual signs of septicemia other than elevation of temperature. A transient bacteriemia of hemolytic streptococcus is possible to exist secondary to a mild throat infection of the same organism, with rapid and complete recovery with no apparent ill-effects. If the temperature has not been high or rash had not appeared, the case would have resembled thousands of other mild "grip" or throat cases in which a bacteriemia was not suspected and consequently a blood culture was not taken.

CONTROL

The common cold, and the mild acute respiratory disease is extremely difficult to control. Prevention depends not so much on the enforcement of any specific precautions as it does on the recognition of the seriousness of the secondary consequences to the individual and to the community. I agree with Zinsser when he says that nothing of any moment will be accomplished in this direction until education of the people has sufficiently progressed to lead to greater personal cleanliness and hygiene; to the realization that a person with a cold should be temporarily segregated from school, factory or office; that sneezing, coughing and spitting in public places is a source of great danger; that people with colds should not kiss others, should sterilize or burn their handkerchiefs and should avoid exposing others by refraining from going to places of public amusement, riding in crowded vehicles,

etc., until the excretory stage of the malady has subsided. Protection is possible only by so organizing community life that routine contact of individuals with infectious material may be reduced to the smallest possible extent and thus influencing the habits, nutrition, occupation, etc., of the community that the average resistance of the population may be maintained at the highest possible level, adding specific prophylaxis whenever possible. Such a program involves technical sanitary organization, also educational and administrative activities.

There is little excuse for the indescribable prevalence of ignorance of the rules of infection in our well-developed public school system. Public education is a most important factor in the successful maintenance of public health.

CONCLUSION

I am led to believe that the acute respiratory disease group is due solely to specific microscopic and submicroscopic organisms.

These factors can be stopped by blocking transmission, and raising resistance. All other manifestations of acute head disturbances resembling acute or subacute respiratory diseases (and I refer chiefly to the common cold) are due to other disease entities which do not have as their basis an acute infectious process. These entities are: atmospheric exposures, vasomotor rhinitis in all its variations, dental infection, and chronic paranasal sinus disease. This in my experience will explain nearly all of the acute respiratory group of diseases and are combatted most successfully if approached from this simple logical point of view.

DISCUSSION

Dr. Kenneth Blanchard, East Orange: Dr. Greenfield's valuable paper impresses one with the tremendous loss that results each year in the education and training of children, because of their impaired efficiency and loss of time produced by frequent colds.

Since bacteria are always with us and as the mucous membranes of the nose and throat are never free from bacteria, it is important that predisposing causes that incite a stirring up of the bacteria present should be eliminated as much as possible.

Dr. Greenfield stresses the frequency of acute respiratory infections, with the common colds making up the greatest portion of this group. He has shown the frequency of pathogenic bacteria during the active process and has named the prevalent types. He also states that the beta hemolytic streptococcus is a chief offender, and that its capacity to produce disease depends on its virulence which can be measured by its hemolytic action in the laboratory. He has shown that when active cultures are obtained from a certain percentage of people, an epidemic may be near. This information is valuable because it is definite and tells when we may expect trouble.

He also emphasizes the predisposing causes which are most apt to be neglected or overlooked, particularly in children. Nasal sinus trouble is much more common in children than is ever suspected. Many children develop nasal sinus trouble after a severe attack of grippe, even in infancy, and it may be undiscovered until later years.

Other causes of upper respiratory infections are insufficient or improper diet, insufficient or too much clothing, damp cold feet, drafts, anatomical nasal defects, enlarged diseased tonsils and adenoids. Kerley feels that a diet containing too much sugar increases a child's susceptibility to colds. I believe that a common cause of acute respiratory infections among school children, in spite of the fine school buildings and equipment that we have today, is the fact that many schools fail to provide three great factors—an even temperature, proper humidity, and a free circulation of air. When air-conditioning has reached perfection and good air-conditioning is installed in our schools, I believe that colds among school children will be greatly reduced.

If the money expended in equipping and maintaining elaborate swimming pools in many of the larger schools was spent for air-conditioning equipment; and swimming pools, which are a constant source of infection, were eliminated, we would be going far in the right direction.

DIAGNOSTIC VALUE OF OPTIC NEURITIS AND CHOKED DISK IN NERVOUS AND MENTAL DISEASES

By Arcangelo Liva, M.D., F.A.C.S., Hackensack, N. J.

Read before the Eye, Ear, Nose and Throat Section of the Medical Society of New Jersey, at the Annual Meeting in Atlantic City on June 7, 1934

During the several years of my general practice many mental and nervous disease cases came under my observation, and my interest was stimulated in the fundus findings of the individual cases whose diagnosis was either corroborated or actually made by such fundus examinations.

I have had several cases, mental and nervous disease cases as well as many intracranial conditions, since I specialized; and I have given considerable attention to the fundus manifestations which I am about to enumerate briefly with the hope of making this résumé of some interest.

DEVELOPMENT

The "eye" and the "brain" have the same origin; the optic nerve makes up a part of a nerve trunk and may be affected by the same lesions that affect the trunk, in-as-much that the arterial and venous circulation of the optic nerve and retina depends upon the intracranial circulation (internal carotid and cavernous sinus). The location of the nuclei of the oculomotor nerves in the bulbo-protuberant region, and the relations of the oculo-motor nerves in their course to the base of the brain, readily explain the frequency of their pathology in the bulbo-protuberant and basilar processes. The complicated innervation of the pupil is frequently altered in the course of chronic infections of the central nervous system. Also, certain hemispheric lesions bring about disturbances of the retinal sensibility. These are some of the reasons which explain the great importance given to the objective and functional examination of the visual apparatus in the neurological analysis of a patient.

In the ophthalmoscopic observation of a case I will describe the papilla, optic disc, and choroido-retina as found in several diseases in which the ophthalmologist may be consulted by the neurologist.

SYPHILIS OF THE NERVOUS CENTERS

The syphilitic infection is frequently localized in the central nervous system and gives rise to four clinical manifestations:

1. Cerebral syphilis, including syphilis of the meninges, syphiloma, and lesions of the encephalic vessels.
2. Tabes, or locomotor ataxia.
3. General paralysis.
4. Hydrocephalus.

Cerebral syphilis includes three conditions:

a. Diffuse meningeal syphilis, which frequently presents bilateral papillary edema, as well as optic neuritis.

b. Localized meningeal syphilis, presents oculo-motor disturbances and papillary edema resulting from hypertension of the cerebrospinal fluid.

c. Cerebral syphiloma presents papillary edema.

Tabes: The ophthalmoscopic examination commonly reveals optic atrophy, which is the most serious manifestation of tabes. The atrophy is always bilateral. The papilla is always discolored, white, its margins are distinct and the vessels are not altered. Atrophy of the optic nerve is found in about 10 per cent of the cases of tabes and may be found at any stage of the disease, most frequently in the preataxic stage, sometimes preceding all the other symptoms of the disease by several years, this fact then being of great diagnostic importance.

In *general paralysis* we find the same fundus changes that we encounter in tabes.

In *hydrocephalus,* contrary to what we might expect, we do not find papillary edema, but the disturbances are limited to atrophy of the optic nerve with complete discolorization of the papillae. Rochon-Duvigneaud demonstrated that this atrophy resulted from tearing of the optic nerves and chiasma, verified by me in two cases.

TUBERCULOSIS (MENINGEAL AND CEREBRAL)

These affections do not present any special characteristic. The meningitis may develop without the ophthalmoscope showing any marked change in the papilla, or the membranes or of the vessels of the fundus oculi. The changes may appear only in the last stages of the diseases; they affect then the choroid, retina or optic nerve. In one-third of the cases, tuberculous granulations of the choroid have been demonstrated by Uhthoff, limited to the posterior segment. These granules present the shape of white points with cloudy margins and with a variable shadow. They are diagnostic of "diffuse tuberculosis". As to the retina, hyperemia is about the only pathologic manifestation. On the contrary, the optic nerve may present a neuritis characterized by an oedematous tumefaction of the papilla and some alteration in the vessels, showing a constriction at the same level of the optic nerve. Considering, therefore, all the fundus lesions, optic nerve and choroid together, neuritis, choked disk, hyperemia and tubercles of the choroid, we will find, according to Uhthoff, pathological changes of the fundus in about 49 per cent of the cases of tuberculous meningitis.

An "intracranial tubercle" may give rise to an ocular symptomatology identical to that of intracranial tumors. As in these affections, we would observe a papillary oedema. This, however, would not be diagnostic of its localization.

CEREBRO-SPINAL MENINGITIS

Optic neuritis is found in about one-fifth of the cases of this disease. The neuritis is almost always bilateral and in the later stages of the disease it is generally followed by a complete atrophy of the papilla. Choked disk as well as retinal hemorrhages are rare.

Netter and Rochon-Duvigneaud reported distinct visual disturbances in some cases of cerebro-spinal meningitis, but there was complete absence of fundus lesions. It seems that the disturbances were due to a complete amaurosis, which disappeared after several lumbar punctures, this indicating an hypertension of the cerebro-spinal fluid.

OTITIC MENINGITIS

Here we find papillary oedema in about 25 per cent of the cases, provided there is a cerebellar abscess. In some exceptional cases, the extension of the meningeal infection to the meninges of the optic nerve will give rise to an optic perineuritis (meningitis) followed by optic atrophy and consequently loss of vision. Rarely we may encounter a papillary oedema which, although very marked, may exist without loss of the visual function.

MULTIPLE SCLEROSIS

In about 50 per cent of the cases of this affection we find atrophic discoloration of the papilla, although not necessarily are both nerves affected at the same time. Usually, however, there is an atrophy of the bi-temporal halves of the optic disc. I have seen three cases of multiple sclerosis, recently referred to me for fundus examination by the family physician. Very rare is the presence of papillary oedema.

CEREBRAL TUMORS

These give rise to papillary oedema or stasis. The latter is present in about 50 to 60 per cent of the cases; and if we add to it the cases of papillary oedema and some atrophic lesions of the optic nerve, we will conclude that involvement of the optic nerve is found in about 88 per cent of the cerebral tumor cases.

In cases of tumors of the bulbo-protuberant region, papillary stasis has been equally observed, but with less frequency say in about 30 per cent of them.

According to Oliver, in subtentorial (cerebellar) tumors, the disc looks denser and harder than in cases in which the tumor is located in the cerebrum.

AFFECTIONS OF THE HYPOHYSES AND INFUNDIBULUM

Frequently modifications of the optic nerve are met with in these cases; about 50 per cent of them present either atrophic discoloration of the papillae or papillary oedema.

Papillary atrophy may exist on one side only for some time and the other eye may not become affected for several years, until the ad-

vanced stages of the disease. The papilla is white, with marked contours and without vascular modifications; in some cases atrophy follows the oedema; then the papillary contours are prominent and the retinal veins are dilated and winding.

Myelitis of the cord is rarely associated with optic neuritis; and if this exists, it is usually bilateral.

In multiple neuritis, optic neuritis is usually, but not always, present.

In migraine, we sometimes find optic nerve atrophy, but only in cases of long standing and very persistent.

In neuralgia, when we find optic nerve atrophy we should suspect glaucoma.

Amaurotic Family Idiocy. A characteristic of this rare family disease is optic nerve atrophy as well as other changes of the macular region. In the latter we may see a "cherry spot" simulating that of embolism of the central artery, surrounded by a pale area. The disc becomes gradually atrophic, blindness being the final result. The pathologic changes of the eye consist in a degeneration of the ganglion cells of the retina and the fibres of the optic nerves.

In acromegaly we may find bilateral optic neuritis and optic nerve atrophy.

Syringomyelia rarely presents optic nerve atrophy, of which only three cases were found by Maixner out of thirty-two.

Chorea is often associated with a low grade neuro-retinitis, and sometimes shows a distinct papillitis.

Exophthalmic goitre, among the other eye symptoms, usually presents for observation also optic neuritis and optic atrophy.

DISCUSSION

Thomas S. P. Fitch, M.D., Plainfield, N. J.: Dr. Liva has clearly shown us that ophthalmoscopy is one of the most valuable diagnostic procedures that we possess. It is a sign-post which may be of great value in guiding us in the right direction for a correct diagnosis in many obscure diseases. Many times it is a sign-post which presents no legend and merely indicates a path to follow in reaching a diagnosis.

Both papilledema and optic neuritis should make us consider brain tumor as our first thought. Many times the characteristics of optic neuritis merge into those of papilledema and vice-versa to such an extent that it is impossible to distinguish which fundus condition is present.

If we consider all obscure nerve heads in the fundi as suggestive of brain tumor until ruled out by the exclusion of other confirmatory signs, we will be able to pick up more brain tumors in the early stages when surgical treatment is most valuable.

There is one condition which Dr. Liva did not mention, probably because of its rarity, but it is one of the interesting eye ground findings which bears the name of the disease. It is Lindau's disease where we find angiomas of the retinal vessels which appear particularly in the peripheral areas and, when accompanied by cerebellar signs, practically render our diagnosis certain.

I want to congratulate Dr. Liva for the excellent way he has condensed such a vast and important subject.

Karl Rothschild, M.D., F.A.C.P., New Brunswick, N. J.: In the absence of Dr. Beling, who was scheduled to discuss Dr. Liva's excellent paper, I feel that another neurologist should take part in this discussion.

We, as neurologists, are concerned with the topic presented by Dr. Liva from the standpoint of mechanics. To us, the optic disc presents the only place where we can actually see a part of the brain, and our interpretation of the symptoms and signs of the papilla is guided by this aspect.

It is a fact that early choking of the disc is most prominent in disturbances caused by neoplasms in the posterior fossa of the skull. The common interpretation of this phenomenon is that the tumor, through pressure, causes a direct obstruction of the venous flow. We have, however, seen tumors of such small size that this interpretation does not seem to cover the ground. It is my opinion that we have to look a little deeper into the mechanics of this phenomenon. There is a possibility that the pressure of the spinal fluid is being controlled by a center located somewhere in the region of the gray matter surrounding the third ventricle or in one of the subthalamic ganglia. It would then be easily understood how even a slight interference with this center of regulation could cause a rise in the cerebro-spinal pressure.

On the other hand, we must never forget that in many cases of brain tumors, there is no choking present in the optic discs. The fact of a normal disc does not exclude a brain tumor. In such cases we will have to be guided by clinical signs and if those should be missing or indefinite in character, we would have to resort to encephalography or ventriculography as a means of diagnosis.

DISEASES OF THE EXTERNAL EAR

By C. N. Dezer, M.D., Hackensack, N. J.

Read at the Annual Meeting of The Medical Society of New Jersey, before the Section on Eye, Ear, Nose and Throat, on June 6, 1934, in Atlantic City

In dealing with external diseases of the ear, we come in contact with dermatology and general surgery. In this paper I have made no attempt to take up the very rare or special diseases, but more practical problems.

The anatomicphysiological knowledge of external ear is important, which I will discuss very briefly.

The external ear is composed of bone and cartilage; the external canal is lined by skin and contains cerumenal glands which secrete a wax-like substance, which in turn protects the membrane tympani from drying and injury. The external canal in the adult consists of two parts, a membrano-cartilaginous tube and asseous tube to which the former is joined, and at that junction the caliber of the tube becomes smaller and widens and we approach the ear drum.

The auricle itself is composed of skin, cartilage and muscle and is so constructed as to best catch sound waves and deflect and reflect them in such a manner to produce best effect on middle and internal ear.

FOREIGN BODIES

Foreign bodies very frequently find their way into the external auditory canal. They may be introduced intentionally or by accident. Young children furnishing far the greater number of patients. The foreign bodies vary from a small seed to a piece of crayon.

In removing a foreign body we must have good light to determine size, shape, etc., of object. Next, it is a matter of choice whether we will syringe the foreign body out by a forceable stream of water. If it is impacted in canal and foreign body giving pressure causing an inflammatory swelling of the membrano-cartilaginous meatus, this may be relieved by using instruments, such as hook, dull ring currette, adjustable ring currette. Forceps may be used, but I do not advocate it as the canal may become injured and foreign body pushed beyond isthmus of canal and give us considerable difficulty. I have had such an experience and it required an operative procedure for its removal. A good axiom to follow is the one by Bezold, never attempt to remove a foreign body when the canal is swollen unless the patient is under an anesthetic. This is most important in children where they may suddenly move their head and foreign body be pushed beyond the isthmus and even through the drum membrane necessitating separation of external canal from the bony posterior canal wall before removing the foreign body.

TRAUMATIC AURICULAR DERMATITIS

An inflammatory condition may result from contusion or abrasion of the skin of the ear not causing any injury to the cartilage; local reaction is one of the erythema which usually runs a benign course or occasionally may become pustular in character. Treatment consists of cleansing of the area thoroughly with any antiseptic drug. If much pain is present, it is well to protect the ear by means of a large dressing of sterile gauze, and if necessary this may be wet with Burrows solution and boric acid.

PRESSURE AURICULAR DERMATITIS

Occasionally one sees lesions, particularly on the helix, which may resemble tuberculosis, syphilis or cancer, but on careful diagnostic procedure the lesion is occasionally found to be the result of pressure. I have one such case in mind: A nun who wore a close fitting veil and developed this necrotic area on the helix. This patient was treated by several men with a considerable discussion as to the diagnosis. She was put to bed for one week, all pressure removed, with resulting cure. This was just one example of the type of pressure dermatitis, and shows the importance of getting a very careful history of the onset, duration and occupation which many times helps us in turning a rather difficult diagnosis into a simple one.

ERYSIPELAS OF THE AURICLE

Erysipelas of the auricle is usually secondary to a traumatic lesion or may start in some slight abrasion of the auricle or external auditory meatus; we most frequently see it in ear work following mastoidectomy. Infection does not usually stay localized in the auricle but spreads to the face and scalp. The redness and swelling of the skin are marked and we find a line of demarcation by the inflamed and normal area. This condition is accompanied by severe pain, elevated temperature, and rapid pulse. Treatment: Rest in bed, supportive treatment; locally the usual remedies may be used—wet dressings, magnesium sulphate, painting the area with 4 per cent mercurochrome and various serums. Many men claim excellent results with the cold quartz light, applying it long enough to develop a very definite erythema, claiming that this in many cases will stop spreading of the disease. I have had no experience with this light but think it is well worth trying.

FROST BITE

This year we all have probably seen some cases of true frost bite of the auricle. The position and the structure of the auricle make it particularly vulnerable. The onset is very gradual and the patient is often not aware that the ear is being frost-bitten. The first knowledge of it is the fact that it becomes rather suddenly insensitive to touch. The helix and tip of the lobe are most frequently involved. The appearance of these parts at first is pale or white in color in comparison with the neighboring skin which is usually very pink. This condition may subside, or if the circulation is not quickly reëstablished the part becomes purple and black and later separated as a slough. The newer thought in the treatment of frost bite of the ear or any other part of the body such as fingers or toes is to let it absolutely alone until the part is ready to separate itself; recovery then being quicker and more satisfactory. Treatment locally consists of massage of the ear with snow or cold water, and as circulation gradually returns the next day or two, dry heat may be applied to stimulate the circulation in those parts involved.

AURICULAR ECZEMA

Auricular eczema which we frequently encounter may be divided into two types:

1. The acute form of eczema, seen in the undernourished and uncared for children; digestive disturbances, etc.

2. The chronic form, seen more often in adult life and old age.

The acute auricular eczema may be divided into three stages: The erythematous stage, the vesicular stage, and the stage in which the area involved is completely denuded of its epithelium and presents a raw and bleeding surface. The itching and local irritation is the chief symptom, also at times considerable pain. Most frequent location is the outer half of the membrano-cartilaginous, postauricular sulcus, and parts behind the ears. The treatment consists of proper management, diet, and cleansing intestinal tract. Locally—cleanliness and protection from mechanical scratching, an astringent ointment, such as zinc oxide, white vaseline or a bland boric ointment, as borafax. In acute cases this ointment may be applied once a day and parts covered by dressings of sterile gauze. In cases of eczema where we have a discharging ear and it becomes necessary for the sake of cleanliness to irrigate the ear, the eczematous surfaces should be protected by several layers of white vaseline, as water has a very unfavorable influence upon this type of eczema.

The chronic type of eczema can be, and is at times very stubborn in its resistance to treatment; usually involves the outer half of the external meatus; we find the canal lined with thin scales of exfoliated epithelium. The most prominent symptom here is the unbearable itching which causes the patient to scratch and make the condition more irritated and very frequently lead to an infection of the external canal. Treatment in this type of eczema is proper diet, rest, tonics, cleansing the parts with alcohol, protective ointment of zinc oxide and frequently a 5 per cent tar ointment. This condition usually improves under treatment, but is prone to recur.

AURICULAR PERICHONDRITIS

This condition very often is traced to a direct infection, or from some neglected infection in the external auditory canal. Peri-

chondritis is an infection involving the perichondrium. One of the first symptoms is auricular pain which gradually increases and interferes with the sleep of the patient. Examination at first may reveal a small inflamed area which may spread gradually in all directions over the anterior surface to the extreme limits of the auricular cartilage. In perichondritis the lobe is rarely involved, which aides us in differentiating between more superficial inflammations in which the lobe may be involved. The treatment here is conservative—wet dressings to help control the inflammation. If the inflammation does not undergo resolution, then we must give the patient a general anesthetic, making a free incision through the perichondrium and drain between the cartilage and perichondrium, plus a pressure bandage. This should be dressed daily, being careful to prevent the recurrence of serum and pus beneath the perichondrium. If the infection spreads to the cartilage, then it will become necessary to remove any area of necrosis, because if this is not done the auricular cartilage melts away and we have a very bad deformity.

HAEMATOMA AURIS

Boxing, football and other sports probably give us most of our cases of haematoma auris; a local condition where we have an effusion of blood between the auricular cartilage, and perichondrium and only occurring on the anterior surface of cartilage. Here the treatment, at first, is conservative, hoping that the effusion may absorb. In a case of large effusion where there is a lot of pressure on the perichondrium and cartilage, a free incision should be made, removing the organized clot and pack with a sterile gauze. In this type of wound a small incision or puncture is of no value.

Very frequently auricular perichondritis and hematoma auris are confused. Although these lesions have many similar features they can be differentiated by the history. One is very rapid in developing; the other very slow. Locally the hematoma on transillumination gives a dark purple color over the clot of blood. In perichondritis the swelling is slow and gradual and usually traceable to some point of infection.

LUPUS VULGARIS

A chronic cellular new growth, due to invasion of the integument by the tubercle bacillus, characterized by various-sized soft, reddish-brown tubercles, tubercular and infiltrated patches, usually terminating in ulceration and scarring; sometimes in absorption exfoliation and atrophy. It is rather rare to be seen by the aurist, more frequently seen in the clinic and by dermatologist. The treatment is constitutional destruction of the disease tissue and the use of x-ray and radium.

SYPHILITIC LESIONS OF THE AURICLE

Primary leutic lesions of the external ear are exceedingly rare; secondary lesions in the form of papular or pustular eruptions coincident with other lesions of the body are found to be a fairly common occurrence. The diagnosis is made by a blood examination and their response to antisyphilitic treatment.

HERPES ZOSTER AURICULAR

This condition is rarely seen, consisting of a series of small blebs or vesules on the membrana tympani, the walls of the auditory meatus, the concha, tragus, antihelix and helix. The appearance of herpes is usually accompanied by severe pain for twenty-four or forty-eight hours before the eruption appears. In severe cases there may be a disturbance of hearing, or symptoms of vestibular irritation. This condition should not be confused with a severe tympano-mastoid inflammation, in which there has been no rupture of the drum head.

CANCER OF THE AURICLE

This condition is rather rare, may start at any point upon the auricle, growing rather rapidly and has the characteristic features common to epithelioma, or any other region of the body. There are two methods of treatment:

a. Cure can be accomplished by amputation of the auricle, by diathermy or surgical electric knife.

b. Treat the condition with radium and x-ray, to avoid mutilation, and to accomplish a cure with a good cosmetic result.

The important thing to remember here is that the cartilage of the ear is sensitive to large doses of x-ray and radium. Dr. Harold N. Cole, of Cleveland, advised the insertion of platinum needles. Dr. Earl D. Osborne, of Buffalo, treated these cases with endothermy. All claimed good results if these conditions were recognized and treated early. Dr. A. Lehman, of Texas, has published the most recent work on the treatment of this condition with radium. His conclusions are:

1. If infection is present to a marked degree, it mitigates against cure of the cancer by radiation. If radiation is used in the face of it, gamma rays are the method of choice, for the effect of beta rays on cartilage is similar to that of the infection.

2. The ordinary smaller doses of radiation that will cure the smaller basal cell epithelioma do no irreparable damage to cartilage.

3. If one has a radiation-resistant epithelioma, it is best to use gamma radiation.

4. If one is treating a cancer that has recurred after soft radiation, it is best to use gamma rays of radium. Last, but not least in the treatment of epithelioma, where a cure is our main purpose, we must not let a cosmetic result hinder us from a cure even if it necessitates radical surgery.

FURUNCULOSIS OF THE MEATUS OF THE EXTERNAL EAR

It is one of the most common, most painful and difficult conditions which the ear man has to deal with; it infects only the outer part of the canal. It occurs most frequently on the outer wall or floor, next upon the roof and occasionally on the anterior wall. It has a tendency to recur. The history of a case of furunculosis is usually found in patients suffering with chronic infections who scratch their ear with bobbie-pins or hair-pins, due to the extreme itching; or may be caused by a chronic purulent discharge from the middle ear. Patients suffering from furunculosis have intense spasmodic pain, slight impairment of the hearing, pain on opening and closing the mouth and chewing.

Examination under direct light shows localized swelling in the canal. Careful inspection of the drum membrane is important because if we find the drum membrane intact we can immediately exclude the middle ear as a focus of suppurative inflammation. It is very important to obtain a look at the membrano tympani to be sure it is not acutely inflammed. Palpation will elicit tenderness and pain on pulling the auricle downward. If on moving the auricle the patient does not complain, we can be rather sure that the disease is not located in the external canal.

We are called upon many times to differentiate this condition from an inflammation of a mastoid. The drum membrane in furunculosis, if it can be seen, is usually intact. Mastoiditis drum membrane is usually perforated and can be seen draining pus. Manipulation of the auricle causes severe pain in furunculosis. Manipulation in mastoiditis causes no pain. Pressure over the mastoid behind the postauricular sulcus and opposite the meatus directed so as not to cause any movement of the auricle causes no pain. The swollen tissues will pit on pressure but no bone tenderness can be elicited. Pressure over the mastoid antrum in mastoiditis elicits deep-seated bone tenderness. X-ray pictures are of value in the differential diagnosis. In treating a severe case of furunculosis the patient should be put to bed and given the usual supportive treatment. In the initial stage one may use the wick in the external canal, which may be kept moistened with Burrows' solution; dry heat, such as the infra red ray; hot water bottle. The electric pad is also rather soothing. If treatment does not stop the inflammation and it goes on to the abscess stage, it very frequently ruptures spontaneously. When the inflammation spreads into the surrounding tissues, it is necessary to open incise the infected area down to the perichondrium. After treatment is, local cleansing of the area, avoiding irrigation of ear if possible. In my experience irrigation of ears, with, or developing furunculosis, macerates the skin over the healthy tissue and causes a further spread of the infection.

OTOMYCOSIS

An infection of the meatus of the external ear with a fungus; the more common are aspergillus niger and aspergillus glacus. This

infection is not as rare as one would believe because I have found in my experience, persistant infection of the ear canal that would not respond to ordinary treatment, under careful examination of the material of the ear by a bacteriologist showed it to be a fungus infection. On examination of the ear the entire canal may be involved, including the drum with a moist looking coating like wet blotting paper, of a brownish gray color. This condition may exist for some time without producing any symptoms, but later on inflammatory changes occur and patient has discomfort in the ear. The symptoms vary from a severe itching to pain. The important part of the treatment of this condition is to dry the external auditory canal thoroughly, removing all débris and any that is plastered upon the ear drum, then wiping out the canal with 50 per cent alcohol and applying half strength tincture of iodine. The home treatment consists of the installation of a two per cent solution of salicylic acid in alcohol, which is allowed to remain in the ear for five or ten minutes. When a fungus infection involves an ear with a perforated drum, the infection spreads into the middle ear, the treatment is more difficult and takes a much longer time to be cured. I believe iodine in weak solution and carefully applied is almost a specific for a fungus infection.

SUMMARY

In conslusion, the important things to remember in treating diseases of the external ear are:

First: The fact that we are treating a part composed of skin and cartilage, and that the cartilage is non-vascular, receiving its nourishment from the perichondrium, making it vulnerable to trauma and infection.

Secondly: A careful history should be taken.

Thirdly: An anesthetic should be given for all foreign bodies in external canal where we have any inflammatory reaction present.

DISCUSSION

E. M. Tennis, M.D., Englewood: This is a most timely paper, for in our over-enthusiasm for the unusual and the spectacular, we are prone to pay too little attention to the simple everyday diseases or conditions which constitute the bulk of our cases. There are a few points I would like to make in discussing this paper:

Foreign Bodies in the External Auditory Canal: Foreign bodies are usually easily removed. Occasionally in the clinic a case is seen where the canal has been so traumatized or where the foreign body has been forced into the middle ear with trauma to the drum and ossicle, that it may be necessary to go so far as taking the bony canal down; that is, either doing a Heith or radical mastoid in order to dislodge the foreign body.

Erysipelas of the Auricle: The treatment of erysipelas of the auricle is the same as the treatment of erysipelas of any other affected part of the body except in so far as it is possible to prevent its occurrence as a complication of chronic ear disease by proper toilet of the ear. The results obtained by the use of quartz light, to my mind, are questionable, as erysipelas itself is a self-limited disease. The severity of the disease is greatly mitigated, and its duration shortened by the use of antistreptococcus serum in large and repeated doses.

Eczema: Eczema is one of the most frequent, persistent, and annoying conditions the otologist has to treat. I strongly feel that dietary management of these cases is more important than the local treatment, especially is this true in children. Besides local treatment, these cases should be in the hands of an able internist or pediatrician.

Furunculosis: Furunculosis of the external auditory canal is often a frequent complication in chronic purulent otitis, and where there is a great amount of swelling of the canal, the history is the most important factor in making a diagnosis. In treating furunculosis of the canal with a gauze wick or pack, I cannot over-emphasize the point that the canal should be packed with pressure. The pressure seems to have a beneficial influence in either aborting abscess formation, or, where abscess formation does take place, in causing its spontaneous rupture.

Otomycosis: The importance of bacteriologically examining smears and cultures from the discharge or the scaly débris of the external canal wall and auricle, cannot be over-stressed. Often it is the determining factor in proper treatment and management of a case of external otitis. The infection from one of the numerous fungi can seldom be recognized without bacteriological examination, and without such an examination the condition can be treated only in a haphazard way. The fungi are easily recognized in a smear of the material taken from the canal, and they respond most readily when recognized and appropriately treated with alcohol and salicylic acid, or with dilute iodine.

Edgar P. Cardwell, M.D., Newark: I wish to thank Dr. Dezer for his very interesting and exhaustive review of diseases of the external ear. I was particularly interested in his frank report of personal cases of foreign body in the external canal.

We have all seen or heard of the terrible consequences of inexpert manipulation of foreign bodies in the external canal; and as long as the instruments are available for their apparently easy removal by forceps or curett, etc., we will all probably be guilty of their use. I have caused canal trauma more than once, in the removal of cerumen.

I must speak one word in favor of always syringing out foreign bodies in the canal, even in the case of suppuration or of residual otitis. It is possible by carefully drying the canal and instilling alcohol, or by syringing with alcohol, to avoid complications. Where there is already oedema or swelling of the canal, this should be treated and the foreign body removed by syringing after dehydration of the foreign body and canal with alcohol drops.

Where mastoid, labyrinthine or meningeal disease supervenes on first inspection, operative treatment is indicated, but a trained ear man should have no such complications from syringing out a foreign body from the external canal.

S. T. Hubbard, Hackensack: I would like to report a rather unusual accident which resulted in leaving a foreign body in the ear of a patient suffering with acute purulent otitis media, whose ear drum I incised. Ether anesthesia was used and the reflexes of the patient tested by pressing the ear speculum well into the narrow part of the external auditory canal. The patient showed no evidence of pain and I incised the drum. As the knife pierced the ear drum the patient suddenly swung the arm upward striking my operating hand and causing the small blade of the knife to remain in the ear. The profuse and persistent bleeding made location and removal of the blade impossible and the patient had to be left until the bleeding stopped. The following day vertigo and nausea were severe and, though bleeding had stopped, the knife blade could not be seen. The patient was taken to the hospital and the giant magnet used, with instantaneous withdrawal of the foreign body resulting. The patient's vertigo and nausea cleared up at once and she made an uneventful recovery.

THE NEW JERSEY MEDICAL SOCIETY ORGANIZES TO IMPROVE COMMUNITY HEALTH SERVICES

By LeRoy A. Wilkes, M.D., Trenton, N. J.

Executive Secretary, The Medical Society of New Jersey

Read at the Sixtieth Annual Meeting of the New Jersey Health and Sanitary Association in Asbury Park, November 16, 1934. This paper was presented in conformity with the plan approved by The Medical Society of New Jersey to encourage its staff and members to present before other community groups the projects and plans of The Medical Society and to acquaint the public with the contributions made by the organized medical profession to the general public.

There are people who still demand and can afford to pay for custom-made clothes, and for being shaved by the barber. Some few people still have custom-made automobiles. These persons no doubt represent the minority, but the *majority* of people still want a physician of their own choice—one who has made a special study of *their* minds and bodies; *their* hopes and ambitions; *their* aspirations as well as their respirations, and *their* difficulties as well as their diseases.

INDIVIDUALISM IN SICKNESS

Personal ambition adn concern run high in times of illness. Cost is a second consideration. Expensive private hospital rooms and individual day and night nurses are demanded by the struggling young man for *his* wife who is undergoing a perfectly physiological process which though painful is comparatively safe.

The physician often suggests that, from the medical viewpoint, less expensive provisions will do equally as well under the circumstances, but what chance has such advice against the strong emotions of the time. After all, our "kicks" in life come from our emotional transgressions.

Artists of all types have always been individualistic and to them we owe much of our present culture and progress. The physician is still both an artist and a scientist. He is also an individualist—through training and experience. Organized effort is new to him outside his workshop—the hospital—but is becoming increasingly evident.

The individual artists of all kinds are having a difficult time—photography and printing is now done in colors, and commerical art has progressed far. These arts have passed largely into the hands of those who have *organized*

their efforts. The trend everywhere is definitely toward organized effort.

ORGANIZATION OF MEDICAL SERVICES

For some types of medical care, organized efforts to provide service, if *professionally* approved as to *quality,* might prove beneficial. One should not be dogmatic in his opinions. Industry and the schools have experimented in using organized medical services, with variable results as to efficiency and economy. In illness it is questionable whether a community health service of really adequate quality and quantity can be effectively furnished to everyone at a cost which he can afford to pay. The community must in any case contribute toward service for the indigent. Certainly much can be said for the *idea* of organized medical efforts, but no one has yet convinced the leaders of medicine that proven and effective *ways and means* of furnishing such medical services in a community, at a reasonable cost under governmental auspices and control are now known and available. Most foreign systems of medical service are unsuited to this country, and the quality of service given there is inferior to that available in the U. S. A.

The question of "State Medicine" is a controversial subject and its practicability and effectiveness will only be finally settled through experimental efforts under medical control and direction, and based upon sound logic and the outcomes of earlier and extensive experience in medical practice.

The members of The Medical Society of New Jersey are becoming better organized and are experimenting as a professional group with the aim of contributing directly, if possible, to the solution of the problem of better distribution of medical care, and thereby to the health of the people, in our State. As individual family physicians and also as delegated representatives of organized medicine, the members of the Medical Society endeavor to coöperate in Community Health Projects, especially in providing adequate medical supervision and care for the indigent, and those in the low income levels.

Public Health organizations, both private and public, are generally concerned with those problems which affect a sufficiently large number of persons in the State or community to require some *organized attack for their control or amelioration.*

In every state and in the larger communities there are *two distinct types of organizations concerned with Health Service,* viz:

1. Those founded *primarily to render health service.*

2. Those founded *primarily for purposes other than health service* but in which the health implications are important factors.

As examples of the first group I would mention the Medical Society, and the Public Health Department. In the second group are the Public Schools, and the Social Agencies providing relief and readjustment for the poor and the helpless.

There is *need for both types* of organizations—each operating within its proper scope of function and calling upon each other for that contribution which each can best provide.

TYPES OF INDIGENCY

The best methods are evolved out of experience. To meet changing conditions, organizations must *continually study* the public needs and how best to meet these in the order of their *urgency.* Today we have a *new type of indigency.* A large number of persons who are ordinarily self-supporting citizens, are in need of aid and assistance. In addition to these we have the "chronic" indigents. *The former do not wish to be classed with the latter group—and they should not be so confused and combined.* This would penalize them for their past self-support. Yet in many hospital clinics established solely for the chronic indigent of the community and already overcrowded, these unfortunate, both "acute" and "chronic" indigents, are being crowded out by those who can still afford the services of a private physician and who therefore are not eligible to free service. Certain of these solvent persons are expressing surprise and even indignation that the physican protests against their demand to be furnished medical service free. Many have been "educated" to believe that such free service is offered not only to those who *can* not afford to pay for private care, but to those who *will* not pay.

Medical service is an essential public utility

and should be available to all—including the indigent, but so must other essentials be provided for all. The community provides for most of the essential needs of its poor, but they are not furnished free—not even the advice of the minister, the lawyer, the public health nurse and the social worker. Someone in the community pays these workers. The physician alone provides continuous free medical service to the indigent, and the abuse of this charity by solvent persons is destroying the altruistic spirit in the younger physicians, whose increased cost of preparation for medical practice is met by a declining income at this important period when he can no longer be helped by the older practitioners who themselves need all their income.

The Medical Society of New Jersey is experimenting to solve two urgent medical problems, especially for the indigent and for the considerable number of persons whose income is so precarious as to cause them to vacillate above and below the borderline of indigency.

THE E. R. A. DEMONSTRATION

In coöperation with the State *Emergency Relief* Administration, medical care is provided at reduced fees arranged under a mutual agreement and paid for by the E. R. A. for their authorized cases, for the acutely indigent who can no longer afford to pay their own physician. A patient does not have to be "on relief", as provision for *medical care as a single phase of relief* has been provided. Details of this plan are to be found in the Journal of The Medical Society of New Jersey for the past year, and also in the E. R. A. County Directors' bulletins.

Briefly the plan is this:

The sick or physically defective indigent applies to the E. R. A. district offices for an authorization to visit his physician—in an emergency he goes *directly*. His physician assumes the responsibility for his medical care. After the first visit a new authorization must be secured by the patient for the estimated number of visits needed—up to five. Additional visits must again be authorized by the E. R. A. (as needed) after each fifth visit.

Much bookkeeping and investigation of the patient is necessarily involved since *public funds* are used and must be accounted for. The physician receives one dollar for an office visit, and two dollars for a "home call" within the county.

Free service is still given in excess of the paid service. All hospital cases are treated free by the physicians. The hospitals are paid by the E. R. A. for their services.

Increasing experience on both sides tends to improve the service, but "red tape" and delay are still the paramount difficulties met. A new appreciation of the difficulties involved in medical service and in administration has come about on both sides and this has had the effect of lowering enthusiasm for "State Medicine".

The outcomes of the E. R. A. Medical Relief project will have been distinctly "educational" to all concerned, as well as beneficial to these indigent patients.

THE PUBLIC HEALTH HOUR

The second project is operated in coöperation with the State Department of Health, and aims to reduce still further the deaths from diphtheria which are greatest in those years before the child enters school for the first time. (55 per cent below 6 years.)

Vaccination against smallpox and immunization against diphtheria are offered in the "Public Health Hour", held at stated intervals in the doctor's private office. The charge is nominal (one dollar per visit with one or two visits necessary). Free services to indigents is offered. The vaccine and toxoid used are furnished free to physicians upon request made to the State Department of Health distributing stations in accordance with the law passed this year in the Legislature. This service is strictly limited to those services which protect the patient *and the community.*

It is a clinic service in the physician's office and is therefore not the same as a private medical consultation in the physician's office. Other projects are now being studied for later offering to the public. These will be made available as soon as the present program is well established and in effective operation.

The members of the Medical Profession as individuals have been the pioneers in experi-

mentation. We are now experimenting as a Professional Society in a limited program. Physicians have not been greatly impressed by their observations of large scale experiments—i. e., prohibition. We prefer to do *well* one or two things at a time.

CO-OPERATION, VOLUNTARY OR COMPULSORY

Experimentation is now the order of the day—with our President in the forefront. He has set the example and the pace. With many of the *aims* expressed, the Medical Society members are in sympathy. Some of us are frankly a bit skeptical as to the *ways and means* suggested to date, for furnishing medical services in all economic levels, but—

All professions and trades are affected by the experiments in operation today. So are agriculture, industry and commerce.

Organized effort is being made compulsory by actual legislation and frequently by executive requests—which are equivalent to an order.

It is fast becoming an issue between voluntary and compulsory "coöperation". We physicians must avoid at all costs conscious or unconscious *exploitation* by governmental decree.

There has been much praise for the accomplishments of the Medical Profession in the last half century. It is the *distribution* of medical services which presents our greatest problem at this time, according to our critics. Certainly there is always room for improvement—but how? Only experience and experiment can determine the most effective ways and means.

MEDICAL LEADERSHIP IN NEW JERSEY

The organized efforts of *The Medical Society of New Jersey* have for years been directed toward the improvement of the physician's professional knowledge and practice in the belief that when called upon he will provide greater service to his patients. To this we have added our present experiments in community coöperation which are directed toward further improving the distribution of the services of our members to those who are indigent, or below the "comfort level" which provides other essentials in maintaining health and self-respect.

Especial interest is being shown in the problems of the children. This is the most promising field for Community Health Services by the Medical Society—especially in the field of prevention. Modern medical practice also recognizes the part played by environmental hazards, contaminated water and food supplies and bad housing. Superstition, ignorance, and traditions established long ago by philosophers and health advisors, who are unacquainted with the conditions which prevail today, are real handicaps of progress. Of these false prophets we still have a goodly number in the commercial field—especially those who advise over the radio.

Contrary to the opinion of many persons, the physician is an extremely practical fellow in his medical practice. *His training and experience are practical.* He studies the causes and effects of death in order to avoid or combat these successfully, and he works on and with *real people* at all times. Human beings both in illness and in health have aspirations, hopes, and ideals, many of which they can achieve only with the combined help of all of us here today. We do not yet know all we should like to know in order to serve the public better, but through the daily practical trial and error and investigations in connection with our work, much has been achieved in the past. Let us all study and experiment as scientifically as we can, and work together in the hope that out of the many *new* ways suggested, we may finally find a *better* way to serve.

This is the aim of The Medical Society of New Jersey.

INDUSTRY'S CONTRIBUTION TO THE COST OF MEDICAL CARE

A PLAN FOR PUBLIC DISTRIBUTION OF MEDICAL SERVICE AT REASONABLE RATES

By Francis H. Glazebrook, M.D., F.A.C.S., Morristown, N. J.
Medical Director, New York Stock Exchange

So much has been said about the cost of medical care that I mention the subject with considerable trepidation. Since the Report of the Wilbur Committee appeared, National Societies, County Societies and individuals have vociferously argued pro and con. The majority report, various foundations and sociologists tell us that "the present plan of distribution of medical service is inadequate and the cost prohibitive to millions of the public." So far as I know, there has been, however, no uniform practical suggestion of organized effort on the part of the medical men to meet this challenge.

On one hand, we have been told what the profession should not allow, and, on the other hand, that the issue must be met, unless we wish to surrender to those who seem insistent upon forcing through some political control of medical practice. A few independent groups and County Societies have started something in an effort to meet the issue, and in some communities hospitals are offering a limited hospitalization service on a yearly contract basis, but nothing has been offered to cover medical service in its entirety, which is possible of adoption by the profession at large.

Irrespective of what we think, or say what you will, the forces at work are powerful and, under the changing social conditions in the world today, with the trend of governments toward centralization of power, it is entirely possible, in fact certain, that unless the profession recognizes the facts and adjusts its practices to meet the changing conditions, the State will take a hand in the adjustment. The Federal Government has delayed action to date to give our profession a chance to suggest some practical plan. And in the words of Thomas Carlyle, "The way to it is to try it, knowing that they shall die if it be not done." Dr. Thomas Parran, Jr., Health Commissioner of the State of New York, at the Cornell University Medical College Commencement this year said (and I quote from a newspaper report): "This ideal may be attained by a form of State medicine or socialized medicine, or both." Dr. Parran asserted that the total cost of providing all the medical care needed by the people in this country is easily within the collective ability of the State and Nation to bear.

Now is anyone so stupid as not to realize the full significance of this statement? It is my opinion that some day prosperity will return "in all its splendor"; and the thing to look out for is that we avoid being victimized by emergency measures designed to meet present-day needs but which may be difficult of readjustment when the emergency is over. For this reason, never more than at present, changes should not be too radical, and, while we should do what is necessary in the way of adjustment to meet the crisis, we should avoid doing anything which we may regret tomorrow. This is a time when our profession should listen to and be governed by the tempering influence of the men who know, the seasoned mentalities who steer the straight and unhurried course. "Fads may come and go, crises wax and wane, experiments flourish and die." (Industrial Medicine, April, 1934.)

There is no doubt that the number of people who find it difficult to pay for adequate medical service has increased in recent years, but the time covered by the Wilbur Committee's Report was previous to the depression years and therefore the present increase in unemployment was not a factor in the findings of that committee. The depression has made the situation more serious, but the fact remains that something fundamental is wrong and that we are face to face with a very serious problem.

I believe that the poor people in this country have the best medical care in the world.

There is no one who can not obtain the services of a doctor for acute sickness. No profession is more generous in service to the needy; in fact, doctors have been too lenient in this regard, too unbusinesslike in the administration of their business. The doctor has participated too little in tax money. Few doctors have become rich. Too often they are imposed upon, and the payment of their fees is relegated to the rear. Automobiles and other luxuries are considered of much greater importance.

Any plan designed to reduce the fees for medical service must also include a plan to reduce the number of people who are being treated at no profit to the doctor. It is time to stand up for our rights.

"God and the Doctor we adore
In the time of trouble, not before.
The danger past, both are blighted,
God's forgot and the Doctor slighted."

Contract medicine has been the subject of much criticism, and industrial medicine is classified under this group and has not escaped some of the criticism. No doubt there has been some cause for such criticism. However, the development of this branch of medical practice is one of the outstanding achievements of medical progress during the last two decades, and, in my opinion, most of the criticism has come from those who are ignorant of the facts.

MEDICAL DEPARTMENTS OF INDUSTRY

Comparatively few people—in fact, few doctors outside of those in some way connected with industrial medicine—have any idea of the actual activities of these medical departments of industry. Many millions of dollars are spent by industry every year in supplying medical protection to employees, and in many instances a part of the service is offered to the families of employees. This service has offered the only chance for diagnostic aid to hundreds of thousands of people in this country. The Compensation Laws have not worked out to the benefit of industry, and have forced industry to take a position in medicine in self-protection. By the same token, under these Laws the private doctor is forced to fight for his rights in too many instances.

"It is an ill wind that blows no good", and, while forced primarily to enter the medical field by these Laws, industry has found that supervision of the health of the working man pays; and the experience of industry in this regard has been a very definite factor in bringing about the general recognition of the importance and the economic value of periodic health examinations. Millions of dollars are being paid annually to doctors and nurses and for equipment by our great manufacturing plants. Railroads, insurance companies, banks, business organizations, large retail stores, etc., etc., are supplying a considerable amount of medical aid to large groups of laboring people who could not possibly obtain it otherwise, in my opinion. This contribution to medical care has helped to hold off the very crisis which is facing the profession today. Furthermore, it may be a factor in the final solution of the problem.

The industrial physician is particularly interested in what has been termed "recessive sickness" or deterioration diseases. The great mass of people have little chance to obtain the necessary procedure to deal with this class of health problem. This is an important factor in the present problem of the cost of medical care. In this particular, at least, industry has filled the breach by providing the necessary equipment and the technical experts to render this service to large numbers of people. Through periodic health examinations, resulting in early diagnosis and proper attention to chronic defects or impairments, the study of occupational disease, and the recognition of insidious illness, a service is rendered which the personal physicians of these people could not do, for few have the facilities at hand for such work.

All of this has been of untold benefit to the worker, to his personal physician, who is advised and given the complete data, and to the employer, who benefits by the reduced loss of time through illness and increased efficiency and capacity of the individual, as well as prolongation of the working life of trained workers. When we consider that industrial accidents are responsible for only 10 per cent of the lost time from work, while sickness is responsible for 90 per cent, we can compre-

hend the great economic importance of this service to the employee and the employer.

Industrial medicine has shown that groups of people can be given adequate medical supervision, diagnostic facilities, and ambulatory treatment at comparatively low cost. The larger the group, the smaller the per capita cost. A recent survey of industrial medical departments made by the American College of Surgeons resulted in the standardization of these departments. This survey included the activities of these departments as well as their equipment. A minimum standard was established, and a list of some 400 organizations was published as having complied with this standard.

Feeling that it would be of some interest to ascertain to what extent these organizations were contributing to the cost of medical care, I sent a questionnaire to this group. One hundred and sixty-nine organizations replied to this questionnaire. These figures represent all types of industrial business, organizations which number 40,000 employees to organizations of only a few hundred. The following table tells the story:

Total number of employees in this group	903,832
Average cost per year per person	$7.95
Number of individuals receiving periodic examinations:	
Required	310,134
Optional	183,992
Number of individuals receiving some laboratory work, including x-ray, etc.	673,502
Number of individuals receiving dental inspection and some treatment	266,580
Number of individuals whose families have received assistance by way of loans, special rates for diagnosis and treatment, visiting nurses, Benevolent Societies, etc.	291,122
Number of individuals treated for Tuberculosis in	
Municipal Sanitoria	318,013
Private Sanitoria	210,170
Number of individuals having hospital arrangements:	
Compensation cases only	461,120
General	344,718
Total cost for this group	$7,183,863
Number of employees paying nothing	683,571
Number of employees paying part of cost, through Benefit Association dues, etc.	220,241
Number of full-time Doctors employed	361
Number of part-time Doctors employed	4,038
Number of full-time Nurses employed	632
Number of Dentists employed part time	30
Number of Dental Hygienists	15
Number of Technicians	25
Number of Opticians	4
Number of Attendants (First Aid, etc.)	47
Number of Chiropractors	1
Number of individuals to whom convalescent homes are available	125,000

The United States Bureau of Labor Statistics in 1931 estimated that $72,000,000 were expended annually for medical and hospital services in this connection. The A. M. A. placed the figure at $77,000,000. Personally, I feel, with Dr. Franklin M. Martin, Director General of the American College of Surgeons, that industry spends much more than this annually. I would place the figure at $100,000,000 minimum, for, as Dr. Martin says, many banks, department stores, business organizations, insurance companies, etc., have very few compensable injuries and spend considerable amounts of money for preventive health measures, emergency clinics, endowed hospital beds, sanitoria arrangements, etc. Also, many private practitioners are used by such organizations on call and on a consulting basis. Then, too, the families of the workers, in many instances, are assisted in medical problems through visiting and welfare nurses and clinics as well as hospitalization, through funds for such purposes. The employees subscribe to such funds, as a rule, but in many organizations the employees pay absolutely nothing.

In my experience, there is no attempt on the part of industry to paternalize her people. To the contrary, every effort is made to avoid this. The worker is made to feel that the Medical Department is at his disposal in coöperation with his personal physician and with due regard to his personal rights. It is very defi-

nitely so, as far as I am able to ascertain, that none of the demand for socialization of medicine comes from the laboring and clerical workers at large. Every individual that I come in contact with, in the final analysis depends on the judgment of his personal physician, who, in many cases, is his friend and his last court of appeal. True, they often ask for assistance, but such assistance as is consistent with their rights and with the approval of their personal physician.

It is said by some that industry is taking practice from the private doctor, but when we consider the number of doctors who are paid fees by industry, and the fact that most companies see to it that their people get proper medical care and often help in paying the physician's fee, and, when we consider that a very definite purpose of industrial medical supervision is to eliminate the acutely sick promptly and that they are sent home to their doctors with such diagnostic data as may be available, it is evident, to my mind, that the contrary is the fact and that the private practitioner is referred much work which he would not get otherwise, and, through the early recognition of sickness and prompt action, as well as the requirement of a doctor's statement as proof of illness upon returning to work, much of the drugstore treatment is eliminated and turned to the doctor. Also, the severity and length of sickness is reduced, and the working classes, in many instances, obtain better treatment than they would ever get otherwise.

CONTRACT PRACTICE UNDER A CENTRAL CONTROL AGENCY

We learn from industry's experience that contract medical service under a Central Control Agent, on an annual or monthly basis of payment, for public distribution is a most complicated matter, and, I believe, impracticable for the following reasons:

First, we are dealing with individual physicians practicing independently, who prefer to make their own financial arrangements with their patients.

Second, it is practically impossible for a Central Control Agent to arrange for full medical coverage, which includes house and office visits by the private doctor, consultation with various specialists, operative fees, hospitalization, laboratory fees (including x-ray), etc., etc.

Third, contract medical service requires that some responsible institution or individual shall assume full financial responsibility for the group receiving the service, and pay all or part of the cost.

Fourth, only an insurance company or some insurance organization with strong financial backing could guarantee such service. This injects a third party to participate in medical fees which rules it out, in my judgment.

Fifth, the great mass of American people of moderate means are not inclined to pay for sickness in advance. It does not fit into human nature. (Michigan Plan.)

Sixth, the distribution of medical practice should be under absolute control of the medical profession. No part of a fee for this service should be paid to any administration agency. Community centers and medical insurance plans do not meet these requirements. "Health insurance has always been a weapon of political expediency." (Welner.)

The Milwaukee County Medical Society appointed a committee to present a plan of contract medical service which they hoped would be practical for the physicians in that community. This plan was not accepted by the County Society as a whole, and the committee was continued in power to study the matter further.

The substance of this plan was to have the County Medical Society act as the central administrative unit and to set up a business organization to administer the business details. Any individual caring to join the plan paid an annual fee in monthly installments to the County Medical Society, which, in turn, guaranteed medical service for this fee, the selection of the physician being left to the individual.

I personally do not believe that a plan of this character will be successful in a large way in this country at this time. As a matter of fact, I doubt if it ever will be. The Society becomes the Treasurer, responsible for the doctors' fees. If there are not sufficient funds, the doctor will not be paid. Furthermore, to

my mind, the Milwaukee Plan is objectionable because it involves a business administrator and clerical assistants. The expense of this must come out of the fees paid for medical service. Therein lies the objection to all forms of medical insurance. I think one reason for complaint in regard to the cost of medical service is the fact that it has been customary for doctors to have too set a fee. A fair fee to one may be an over-charge to another. This is also true of hospitals. The fee has been established for different classes of individuals without taking into consideration the variation in the incomes and dependents of individuals of the same classification.

We should establish some method of charging on a sliding scale basis. I am informed that the Mayo Clinic, many years ago, established such a basis of charges. Any one may receive treatment at the Mayo Clinic, and I have never heard a single complaint about the charges at the Mayo Clinic. In other words, fees for administration of all branches of medical service should be on a sliding scale and have a uniform relation to the individual income.

There must be, in any plan for community distribution of medical service, a central authority of control and provision for service to all classes of the public. No plan is adaptable for general adoption. There will have to be variations depending on the size and the character of the community.

Any plan also must include all the doctors in the community, assuring them equality of participation and, to the patient, the same personal independence of selection as prevails under present conditions.

The County Medical Society is the natural body under which to place such administration and control, but I am not in favor of the County Medical Society going into the health insurance business. The officers and Executive Committee of the County Medical Society are elected by the Society yearly, and are a representative group entrusted with the conduct of the Society. I have an idea that the County Medical Society has failed, in the past, to utilize to the utmost its authority in matters pertaining to the business of medicine. We have been too much concerned with the advancement of scientific knowledge and the ethics of the profession, which is all right as far as it goes, but after all there is the business of selling medical service, and this phase of the question has been grossly neglected.

Doctors have drifted along as individuals, and have never adopted business principles; hence, the common idea that doctors are poor business men. The County Society should be given full authority to represent the profession in all matters of interest in the advancement of medicine, but, by the same token, it should also be alert to protect the interest of the doctor in all things political and financial. The County Society should be a militant organization. It should dictate and control medical policies and be controlled by no political or other group.

ADMINISTRATION AND ORGANIZATION BY THE COUNTY MEDICAL SOCIETY

My suggestion is to make the County Medical Society the central unit and the administrative body. The first step should be to muster every physician in the county to the County Society. All members of the County Society must agree upon a plan and also agree to abide by the rules and regulations of the plan. A complete list of all physicians so enrolled should be published in the county newspapers with a description of the plan in full, stating that the doctors listed have agreed to operate under the plan. The Secretary of the Society should be the recording officer and an executive committee should be appointed which should include the officers of the Society and as many others as is deemed necessary to execute the details of the plan.

Any clerical help required or other expense should be paid by assessment, each member participating equally in such expense. This committee should act in all grievance cases, and its decisions should be final. There should be stated times for meetings of this committee and special meetings should be held whenever the occasion arises in connection with the carrying out of the plan.

Any physician who after due hearing is found uncoöperative should be dropped from the roll and his name omitted from the next

published list. He should also be deprived of privileges available to doctors in good standing. In addition to setting up details of this plan, this committee should coördinate all the agencies in the community which have to do with the distribution of medical service. Some of these are superintendents of hospitals, government relief agents, political committees having charge of funds for various municipal activities, etc., etc. To these various agencies, the County Society should present its plan, and insist upon full coöperation.

CLASSIFICATION OF GROUPS RECEIVING MEDICAL SERVICE

The next step is a classification of the public groups according to their ability to pay for medical service. There are three generally recognized classifications. I would add a fourth group.

Group I—The indigent, or those unable to pay for any medical service (an indigent is a resident who requires a type of medical care and treatment and who is unable to pay for such care and treatment from assets in hand or from assets in the hands of responsible relatives.—Alameda County.

Group II—The well-to-do class. This group can be eliminated from consideration in this plan as they are able to make their own arrangements privately, and are not eligible for community assistance.

Group III—This group is above the indigent class, have jobs and can pay limited fees for medical care. Recently, the United States Hospitals Association has approved a basis for determining the people eligible for dispensary treatment. Taking the schedule of that association, I would designate people with the incomes here shown as Group III.

	Annual Income
Unmarried individuals	$ 900.00 or less
Families of Two	1400.00 or less
Families of Three	1650.00 or less
Families of Four	1900.00 or less
Families of Five	2150.00 or less

a. $200.00 should be added to these figures for each additional dependent.

b. If parents and children are working, the total income should be taken.

The Hospitals Association has decided that these people are justified in asking for the rates offered in hospital clinics, and they should also be eligible for ward rates and free treatment if hospitalized. To meet this situation, physicians might adopt the same fees paid to dispensaries for office calls. This, to my mind, is the only way the physician can cut down the dispensary attendance, and it is one way the doctor can add to his income.

I want to say right here that every doctor serving hospitals in the case of ward and dispensary patients should receive some remuneration from the local government for this service. It is time to stop the present unsound procedure. The Epstein Plan which is being proposed for adoption in the various State Legislatures would cost for administration in each state a minimum of $600,000.00 a year. There is no need for any such plan. The medical profession should let it be understood that it will not submit, at any time, to politically appointed administrators; and it should also insist that, instead of raising any such fund to pay the army of employees necessary to administer such a plan, the state and local government pay the doctors who are already holding staff and dispensary positions for services rendered to ward and dispensary patients. Such remuneration may be only nominal for the amount of work done, but there is no reason why the medical profession should be singled out as the only group doing a state duty without pay.

Group IV is the great rank and file of the people, and this is the class who is finding it difficult to finance adequate medical care. Their income rates are about the figures shown in Group III as a minimum and about three times these figures as a maximum. They are being eliminated by the Hospitals Association as being eligible for dispensary care, and they should be; but by the same token, they require some consideration in charges all along the line for medical and hospital service. It is for this group that the agitators are suggesting state medicine on the same basis that they have public schools, police protection and other municipal services.

GROUP IV

	Annual Income
Unmarried individuals	$ 925.00-$2700.00
Families of Two	1425.00- 4200.00
Families of Three	1675.00- 5000.00
Families of Four	1925.00- 5700.00
Families of Five	2175.00- 6500.00

This group represents a large percentage of the people of the country. They can pay their way in part, but as said before, they require fees for medical service in a reasonable relation to their ability to pay, and the only way in my estimation to meet this issue is to have a sliding scale basis of charges arrived at by a definite percentage of their weekly or annual income. It seems reasonable that the individual whose annual income is $1000.00 should not pay the same doctor's fee or hospital rate as the individual in the same class pays whose income is $2700.00 a year. This is something for the County Society to determine; and it should be arranged to cover office visits, house visits, specialists' fees, consultations, operations, hospitalization and laboratory fees. Ordinary short acute illness can be met by this group comparatively easily; but it is prolonged sickness and hospitalization with the payment for operations, nursing, etc., etc., that make sickness a hardship. Under such conditions, it is my feeling that rates should be arranged on the basis of weekly income for all services involved, and the attending physician should compute all the cost in connection with hospital charges, as well as medical and surgical fees. Under present conditions, these people are charged on the same basis irrespective of their respective abilities to pay. "The rates of sickness vary inversely with the ability to pay. The lower the income, the higher the rate." (Bossard.)

TABLE I

Hospital Rates Based on Percentage of Weekly Income

EXAMPLE A

Single individual having income of $18.00 per week.
12% of $18.00=$2.16 per day, or $15.12 per week.

EXAMPLE B

Married individual with 5 in family having an income of $42.00 per week.
7% of $42.00=$2.94 per day, or $20.58 per week.

EXAMPLE C

Married individual with 3 in family having an income of $32.00 per week.
9% of $32.00=$2.88 per day, or $20.16 per week.

It is easily seen that an individual earning $18.00 per week cannot pay $3.00 or $4.00 a day for hospital care, and this is the prevailing ward rate. I offer as a suggestion that the per day charge of 12 per cent of the weekly income for unmarried individuals, and 10 per cent for married individuals without dependents, reducing one per cent for each dependent would be a fair basis of charging for hospital service for Group III. See Table I for hospital charges. They should be eligible for the ward, and no charge should be made for medical attention in the hospital. But the municipality should remunerate the doctors for such ward service.

Group IV will deserve some limitation of fees, and many cases in the lower brackets are also unable to pay more than established ward rates. Where it is possible, this group should be eligible for a "semi-private" rate, and $6.00 per day should be the maximum rate for this entire group in connection with hospitalization, and a full week of hospitalization should not exceed one-half of the weekly wage for an individual with dependents, otherwise it is not possible for the physician to make any charge at all in many cases. We all know that oftimes today, it requires all the money the patient has to pay the hospital bill; and as a result, the doctor goes begging for his fee.

As another example, suppose we take surgical procedures for Group IV. We might classify such procedures as

Minor operations	1
Minor operations	2
Major operations	1
Major operations	2

For minor operations 1, suppose we charge one per cent of the annual income, and for minor operations 2, we charge three per cent of the annual income; for major operations 1, five per cent of the annual income, and major operations 2, we charge ten per cent of the annual income. Taking an individual whose annual income is $1200.00, the following table shows how the charges would work out on a percentage of annual income:

Minor operations Class 1— 1%	$ 12.00
Minor operations Class 2— 3%	36.00
Major operations Class 1— 5%	60.00
Major operations Class 2—10%	120.00

These figures speak for themselves, and the process seems simple and practical.

Laboratory and x-ray services are important

factors whenever the question of the cost of medical care is discussed. It is impossible to practice medicine today without laboratory and x-ray assistance. In many cases, successful treatment can only be obtained by the use of these aids, particularly is this true in connection with recessive sickness. People in the lower brackets of income find the charges for this work prohibitive. The only provision for laboratory work in the average community is the hospital laboratory. In the larger communities, there are private laboratories set up by individuals who specialize in this work.

I have before me the fees charged for some of the common tests in commercial and hospital laboratories. These are in every case the minimum charges.

Urinalysis	$ 2.00
Blood Chemistry (depending upon what is asked for)	$10.00 to $25.00
Complete blood count	5.00
X-ray of teeth	$1.00 to $7.50
X-ray of sinuses	$5.00 to $10.00
X-ray of chest	15.00
Gastro-intestinal series	$25.00 to $50.00
Basal metabolism rate	5.00
Electrocardiogram	10.00

The state laboratories, and in some instances health departments, have some provision for a limited amount of laboratory service free to the public. Doctors who take care of people in moderate circumstances know that their work is often handicapped by the fact that their patients cannot pay for this service under the present schedule of charges.

Every community should have adequate laboratory and x-ray facilities available for all of the people. This is a municipal responsibility, and is a matter to which the County Society should give serious consideration when coördinating the various governmental and social agencies in the community.

Referring again to Group I, or the indigent class, under present conditions in many communities, except for an annual allotment to hospitals, which allotment is usually inadequate to meet the expense of caring for the indigent, no provision is made to pay the doctor for the services he may be called upon to render. Few communities have any plan of medical provision which includes a fee for the doctor's services. It should not be so. The personnel of every other agency in the community receives remuneration, and the doctor should be no exception. I feel that this group of people should be taken care of by the practicing physicians of the community, and that some agency should have the authority to authorize doctors to take care of these people. The health officer or the local board of health seems to be the logical place for this authority. There should be no friend or favor element, the patient having the right to call the doctor he wants, and the doctor should present his bill for services to the agency appointed to administer this service.

In the Milwaukee Plan, there is a provision that after the first call, the doctor should advise the proper authority that he has paid a call on an individual, and he should present a small charge for this call. (This is called a fee to eliminate nuisance calls.) And thereafter the doctor should be authorized to care for the individual at home if possible. If it is necessary to hospitalize the individual, the doctor should so state, and the same agency should authorize the hospital to admit the individual and care for him.

The doctor's fees for services to indigents should be at least what a dispensary would charge allowing some additional charge for house visits. There is no reason why this work should not be distributed among the doctors in the community, and that the patient should not have a doctor of his own selection. Here I refer you to the Gleib-Vaughan Plan of dealing with the indigent in Detroit: "The comparable method adopted here in the last few years by the Federal and local relief administrators, just as the individual on relief has his rent paid and is given food tickets, he receives an authorization for medical care when ill. He may be treated by any licensed practitioner enrolled for this work, and the government pays the bill in accordance with a fixed fee schedule." Certainly, this makes sense.

INSURANCE

Now, in connection with contract service on an annual basis, it is my impression that this cannot be practicable for public distribution. County Societies, to my mind, cannot assume

such responsibilities, and no individual doctor is qualified to take on any such contract, for he would have to be a "general practitioner, surgeon and all other specialists" rolled into one, and all first class. He would have to have all the equipment and laboratory facilities in every field of medicine and be expert in their use. In addition to that, he would have to have the funds to finance the deficit of such a plan until he could put it on a paying basis. Nothing short of a strong group of doctors having a substantial following in the community could possibly consider such a plan. "The thought is this, that the medical profession must assume in each community the entire responsibility for caring for people's health. To do so, physicians must be willing to work in harmony, coöperate in their local medical organization and to sacrifice something of individual independence. Further than this, if the profession is to assume responsibility, it must be in position through its local organization to guarantee a high quality of medical service to all the people." (American Medical Association Bulletin, November, 1934.)

MEDICAL GROUPS

Upon closing, let me speak for one moment of medical groups. This plan of medical service is growing rapidly in all parts of the country. The Mayo Clinic commenced this way, and personally, I believe it will be very largely the plan of the future. There is no question about the advantage to the individual members of these groups, nor is there any question that their ability to render a full medical service is most satisfactory. There are very few lawyers today practicing independently. Lawyers know the value of law firms. It increases their capacity in all branches of the law. In addition to facilitating the practice of medicine, the benefits to the members of such groups are many. Provision is made to protect each doctor against loss from sickness or absence from duties for any cause, and as one grows older, his value to the organization becomes greater and his financial interest is continued in his old age by retirement annuities and other benefits.

In presenting a subject of this nature, it is necessarily involved. I offer these suggestions as at least a possible basis out of which may be found something practicable. All plans for the public distribution of medical service are complicated. I believe, if we adopt a sliding scale basis of fees, depending upon the individual income, that we will go a long way toward solving the problem of the cost of medical care for the public in all groups.

SUMMARY

1. The experience of industrial medicine has shown that limited medical service can be supplied to groups of people at a comparatively low per capita cost when a reliable organization guarantees the cost and assists in the payment of the bill.

2. Contract medical service does not seem practicable for general public distribution. Some group or organization must assume the financial responsibility.

3. Private groups of doctors can give varying degrees of medical service on a monthly or yearly payment basis if they choose to assume such responsibility.

4. A uniform schedule of fees on a sliding fee basis of charges based on the income of the individual is the most practicable and most equitable plan for general distribution of general medical service in full.

5. All medical forces in a community should be coördinated under the supervision of the County Medical Society which should be the central body of control, for only in this way can there be a fair apportionment of the responsibility and the expense of medical care for those with limited income.

6. Such a plan has the following advantages:

It continues the control of medical practice in the hands of the medical profession.

It eliminates the need for medical insurance and all third parties.

It preserves the personal rights of the patient and the doctor.

It allows free choice of regularly practicing physicians by every individual, including the indigent.

It provides that every dollar paid by the patient, donated by charity and raised through taxes is used directly to purchase medical service.

It eliminates high cost of administration and the danger of graft.

STATE SOCIETY ACTIVITIES

A. M. A. HOUSE OF DELEGATES

A REPORT BY JOHN F. HAGERTY, M.D., CHAIRMAN OF THE NEW JERSEY DELEGATION

The special meeting of the House of Delegates of the American Medical Association held in Chicago, February 15th-17th, was attended by a large number of delegates and the results may be considered very satisfactory. New Jersey was represented by Drs. Hagerty, Conaway, Mulford, and Marvel, Dr. Lippincott being unable to attend. Dr. Thomas K. Lewis, chairman of the Committee on Medical Practice, was also present.

As evidence of the interest in the meeting, which was the first special meeting held since the World War, it might be stated that 161 of 172 delegates were present, and there were also officers and official representatives of many State Societies and members of Committees on Economics. These visitors were, on motion, invited to "sit in" at the meeting which was conducted in executive session. The desire of the Board of Trustees to have the meeting express the attitude of the profession of the country is shown by their assuming the expenses of the delegates to and from the meeting and during their stay in Chicago.

It is interesting to learn from a statement of the Board of Trustees, read to the House by Dr. Upton, Chairman, that the subject of social insurance has been studied by the House since 1916, and that in the following year, 1917, resolutions recommending laws protecting the health of the community and safeguarding the practice of medicine were adopted. At that time the principle was established "that all such legislation should provide for freedom of choice of physician by the insured" * * * "and adequate representation of the medical profession on the appropriate administrative bodies". In 1920 the American Medical Association, through its House of Delegates, declared its opposition to the institution of any scheme embodying a system of compulsory contributory insurance against illness or any other scheme which provides for medical service to be rendered contributors or their dependents, provided, controlled or regulated by any state or federal government.

Thus, a decade before 1927, when, under the influence of three philanthropic foundations—The Twentieth Century Fund, the Milbank Fund, and the Rosenwald Fund—a committee of five, later expanded to a committee of forty-eight and known as the Committee on the Costs of Medical Care, was formed to bring out recommendations for providing the American people "with the best type of medical care at a price they could afford to pay", the American Medical Association had seriously considered the subject and had adopted the above principles to which it adheres today.

The Chairman of the Board of Trustees in concluding the official statement, proposed for consideration six propositions concerning the attitude of the House toward health insurance and its relations to the practice of medicine. A reference committee of seven, representing all sections of the country, to whom these propositions were submitted for report, was then appointed by the Chair and the proposals were discussed by the House during the day.

On the following day the Reference Committee's report was presented and actively discussed. The discussion was directed to clarifying certain sections pertaining to the principles of insurance and, upon its re-introduction in the afternoon, was unanimously adopted by the House. The report follows.

REPORT OF THE REFERENCE COMMITTEE
A. M. A. HOUSE OF DELEGATES
February 15 and 16, 1935

Your Reference Committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available to the American people, condemns unreservedly all propaganda, legislation or political manipulation leading to these ends.

Your Reference Committee has given careful consideration to the record by the Board of Trustees of the previous actions of this House of Delegates concerning sickness insurance and organized medical care, and to the account of the measures taken by the Board of Trustees and the officials of the

Association to present this point of view to the government and to the people.

The American Medical Association, embracing in its membership some 100,000 of the physicians of the United States, is by far the largest medical organization in this country. The House of Delegates would point out that the American Medical Association is the only medical organization open to all reputable physicians and established on truly democratic principles, and that this House of Delegates, as constituted, is the only body truly representative of the medical profession.

The House of Delegates commends the Board of Trustees and the officers of the Association for their efforts in presenting correctly, maintaining and promoting the policies and principles heretofore established by this body.

The primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care, and the provision of adequate medical service to all the people. These physicians are the only body in the United States qualified by experience and training to guide and suitably control plans for the provision of medical care. The fact that the quality of medical service to the people of the United States today is better than that of any other country in the world is evidence of the extent to which the American medical profession has fulfilled its obligations.

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal government, the governments of the individual states or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

The medical profession has given of its utmost to the American people, not only in this but in every previous emergency. It has never required compulsion but has always volunteered its services in anticipation of their need.

The Committee on Economic Security, appointed by the President of the United States, presented in a preliminary report to Congress on January 17 eleven principles which that committee considered fundamental to a proposed plan of compulsory health insurance. The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experience in medical practice are found by the committee to be essential to its own plans. (Page 159.)

However, so many inconsistencies and incompatabilities are apparent in the report of the President's Committee on Economic Security thus far presented that many more facts and details are necessary for a proper consideration.

The House of Delegates recognizes the necessity, under conditions of emergency, for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and protests those sections of the Wagner Bill which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes.

The House of Delegates condemns as pernicious that section of the Wagner Bill which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

The so-called Epstein Bill, proposed by the American Association for Social Security now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous and demoralizing measure. An analysis of this proposed law has been published by the American Medical Association. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration and an inevitable trend toward social and financial bankruptcy. (Feb. Jour., p. 106.)

The committee has studied this matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and

willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health, and the curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June, 1934. (Jour., July 1934, p. 427.) The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physician on the other.

Your Reference Committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeitng of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

(Signed) DR. HARRY H. WILSON, *Chm.*, Cal.
DR. WARREN F. DRAPER, Virginia
DR. E. F. CODY, Massachusetts
DR. E. H. CAREY, Texas
DR. N. B. VAN ETTEN, New York
DR. F. S. CROCKETT, Indiana
DR. W. F. BRAASCH, Minnesota

ELEVEN PRINCIPLES IN COMPULSORY HEALTH INSURANCE

The Federal Committee on Economic Security whose appointment was announced on November 11, 1934, (Journal November, 1934, page 651) made a lengthy report on January 16, 1935. At the same time the "Wagner" bill on insurance for old age, unemployment, and some forms of sickness, was introduced in the Senate. (Journal February, 1935, page 106). The report of the Committee set forth eleven principles which it considered fundamental in any plan for Compulsory Health Insurance. These principles were considered in the special meeting of the House of Delegates of the American Medical Association on February 15, and must receive attention in discussing the merits and implications of any health insurance plan. The principles are as follows:

1. The fundamental goals of health insurance are:
   (a) the provision of adequate health and medical services to the insured population and their families.
   (b) the development of a system whereby people are enabled to budget the costs of wage loss and of medical costs;
   (c) the assurance of reasonably adequate remuneration to medical practitioners and institutions;
   (d) the development under professional auspices of new incentives for improvement in the quality of medical services.

2. In the administration of the services, the medical professions should be accorded responsibility for the control of professional personnel and procedures, and for the maintenance and improvement of the quality of service; practitioners should have broad freedom to engage in insurance practice, to accept or reject patients, and to choose the procedure of remuneration for their services; insured persons should have freedom to choose their physicians and institutions; and the insurance plan shall recognize the continuance of the private practice of medicine and of the allied professions.

3. Health insurance shall exclude commercial or any other intermediary agents between the insured population and the professional agencies which serve them.

4. The insurance benefits must be considered in two broad classes:

(a) cash payments in partial replacement of wage loss due to sickness, and for maternity cases, and

(b) health and medical services.

5. The administration of cash payments should be designed along the same general lines as for unemployment insurance; and so far as may be practical, should be linked with the administration of unemployment benefits.

6. The administration of health and medical services should be designed on a state-wide basis, under a federal law of a permissive character. The administrative provisions should be adapted to agricultural and sparsely settled areas, as well as to industrial sections, through the use of alternative procedures in raising the funds and furnishing the services.

7. The costs of cash payments to serve in partial replacement of wage loss are estimated as from 1 to 1.5 per cent of pay roll.

8. The costs of health and medical services, under health insurance, for the employed population with family earnings up to $3,000 a year, is not primarily a problem of finding new funds; but of budgeting present expenditures so that each family or worker carries an average risk rather than an uncertain risk. The population to be covered is accustomed to expend, on the average, about 4.5 per cent of its income for medical care.

9. Existing health and medical services provided by public funds for certain diseases or for entire populations should be correlated with the services required under the contributory plan of health insurance.

10. Health and medical services for persons without income, now mainly provided by public funds, could be absorbed into a contributory insurance system through the payment by relief or other public agencies of adjusted contributions for these classes.

11. The rôle of the federal government is conceived to be principally

(a) to establish minimum standards for health insurance practice; and

(b) to provide subsidies, grants, or other financial aids or incentives to states which undertake the development of health insurance systems which meet the federal standards.

EMERGENCY RELIEF ADMINISTRATION

The State Medical Advisory Committee met on February 7, in Newark, at the E. R. A. Headquarters. There were present, Drs. Snedecor, Fithian, Ely, Sherman, Beling, Pyle, and Hawkes, and Dr. Wilkes, Secretary, of the Medical Society; also Dr. Tooker and Mr. Parker of the E. R. A. In addition, Mr. Dare, a pharmacist, was called into the meeting by Mr. Parker; also Mr. Wolf and Mr. Bacon of the E. R. A. office.

A second meeting of the Advisory Committee was held on February 21st, those present being Drs. Beling, Fithian (proxy), Sherman, Schlichter, Snedecor and Wilkes.

The two principal subjects discussed at both meetings were chiropractors and the formulary.

CHIROPRACTORS

Dr. Snedecor explained that the chiropractors had demanded the right to be recognized as licensed physicians under the laws of New Jersey and to share in the operation of the medical relief program. Mr. Wall, counsel to the State Medical Society, gave his opinion that chiropractors may be engaged on the advice of physicians, and that the specific limitations placed upon the licenses given to chiropractors in New Jersey provided justification in placing restrictions upon the E. R. A. in approving bills for the chiropractors' services, unless these services were given under the advice of a physician.

FORMULARY

A large part of both meetings was devoted to a discussion of several formularies which were proposed, among them being the U. S. P., the N. F., the Pocket Formulary of the A. M. A., and a specific form proposed for the E. R. A. It was finally unanimously decided that the E. R. A. should go to the State and County pharmaceutical societies to make definite arrangements to insure fair charges and supervision by County pharmaceutical societies, under the present drug restrictions and a supplementary list of biologicals and drugs which the E. R. A. had already discussed.

The following resolution of the Medical Advisory Committee to the Emergency Relief Administration was adopted on January 17, 1935:

In view of the approaching end of the present Emergency Relief Administration act on January 31, 1935, and the need for a new emergency relief measure which must take its place, the Medical Advisory Committee wishes to express its opinion

as to the method of rendering medical relief to the people which should be included in the new act.

The experience of the members of the Medical Advisory Committee with the present emergency methods for providing medical relief under a unified state control, in mutual coöperation between the Medical Society of New Jersey and the State Emergency Relief Administration, has on the whole been fairly satisfactory in spite of the many practical changes found necessary from time to time.

Good medical care has been provided to the indigent in a manner acceptable to them and to the majority of the profession at a reasonable cost to the State.

The Committee wishes to call attention to the fact that the medical profession is still rendering a tremendous amount of free care to the hundred of thousands of people in New Jersey who go to the clinics and hospitals, and to those who are treated in private practice without remuneration to the physician. The present fees agreed upon under the relief plan represent approximately one-half of the usual fees; and this income practically represents the over-head costs of services rendered in the majority of cases.

The Medical Relief Advisory Committee of The Medical Society of New Jersey is solicitous that in the new emergency relief act, provision be included enabling the doctors, now receiving public monies in part time positions, to receive additional funds for professional services to relief clients in accordance with the mutual agreement mentioned, and paid for out of the relief funds provided for this purpose.

It would seem advisable that through definite legislation, recognition of the part played by the medical profession should be made in the law naming the State and County Medical Societies as the official agencies to coöperate in the administration of and provision for medical relief services.

We recommend the plan to place a physician, recommended by The Medical Society of New Jersey, on the State and on the County Administrative Councils; and that in principle the present method of administering medical relief be continued.

In view of the tentative relief policies announced by the federal administration, we appreciate that a certain portion of the present relief load may be turned over to permanent state agencies, and that the employable balance of this load may be given employment to provide some sort of public works program at salaries inadequate to provide necessary health services.

In view of this possibility, we recommend:

1. That, the state agencies made responsible for the care of unemployable persons receive sufficient funds to provide adequate health services; and furthermore that, these unemployables cared for under an outdoor relief program be given medical relief under a plan embodying essential features of the present mutual agreement and program conducted under The Medical Society of New Jersey and the State Emergency Relief Administration agreement.

2. That, recognition be given to the fact that the probable income of those employed on public works projects will be inadequate to enable the individual so employed to provide for his own necessary health services; and that, the New Jersey Emergency Relief Administration, or the agency superceeding it, be enabled to provide necessary health service as a supplementary phase of the governmental aid given as salaries.

Spencer T. Snedecor, Chairman,
Charles H. Schlichter,
Christopher C. Beling,
E. Zeh Hawkes,
George W. Fithian,
Byron G. Sherman.

Dr. Spencer T. Snedecor, of Hackensack, was appointed a member of the State Emergency Relief Administration Council by Governor Harold G. Hoffman, and his appointment was confirmed by the Senate. He assumed office on March first. Dr. E. Zeh Hawks, of Newark, succeeds Dr. Snedecor as Chairman of the State Medical Advisory Committee to the E. R. A.

WELFARE COMMITTEE

A meeting of the Welfare Committee of The Medical Society of New Jersey was held in Trenton on Sunday, February 3, 1935, with the Chairman, Dr. Thomas B. Lee, presiding. Those present were: Drs. Lee, Ely, Alexander, Areson, Frost, Green, Haggerty, Herbener, Hoffman, Kraker, Morris, Morrison, Pollak, Sherman, Ulmer, Van Ness, Wilson, Wood, Fischelis, McGuire and Liva, and Dr. Wilkes, Secretary. Mr. MacDonald of the State Department of Health represented Dr. Mahaffey. Dr. Burritt of Union County, and Dr. Brodkin of Essex County were also in attendance.

UNIFORM MEDICAL PRACTICE ACT

The Chairman of the Sub-Committee on the Uniform Medical Practice Act, said that a further meeting is to be held in Newark on February 18, 1935, to consider the tentative draft prepared by Attorney Richman, who was retained by the Committee for this purpose.

FOOD AND DRUGS

There was considerable discussion of the Federal Pure Food and Drug Act, and the enforcement of the Wiley Law which had eliminated many quack cures for cancer, tu-

berculosis, and similar diseases. But new conditions have arisen requiring an extension of the law. It was voted that "The Welfare Committee representing The Medical Society of New Jersey, recommend to Senator Barbour that a congressional investigation of this problem be held".

E. R. A. ADVISORY COMMITTEE

Dr. Wilkes read the resolution of the Medical Advisory Committee in regard to methods of conducting relief work (page 160), and stated that copies had been sent to the Governor, the State Administrative Council, the Committee of the Senate and Assembly, and the County Secretaries. On motion, this resolution was adopted.

Dr. Wilkes and Dr. Ely reported on the conference held with Governor Hoffman, and Dr. Fithian, and Dr. Snedecor. Governor Hoffman was very gracious and stated that there will be a continuation of the State Administrative Council of E. R. A. on which we shall have representation. The County Councils are to be done away with in fact, but may be kept in principle. The Administrative Council will have an executive officer in Newark and he will be in absolute charge over the County Directors. The County Advisory Committees where organized will have no power, but may make suggestions.

The Committee felt that in view of the announced intent of the government on public works projects to pay salaries lower than those paid by private enterprises, it was quite likely that it would not be possible to pay for medical services out of these salaries. Due to this fact the Committee suggested that "some legislation should be made whereby both employables and unemployables would be provided with medical care."

LEGISLATION

The subject of legislative bills was discussed. It was voted that "All bills of a medical nature be referred to a Legislative Medical Bills Committee of five members, for review by at least three members".

The medical bills now before the Legislature were discussed (page 164).

SPECIAL TUBERCULOSIS AND MENTAL HYGIENE COMMITTEES

It was felt by all that much benefit could be derived from two such committees. Dr. Ely stated that he has sent out letters requesting advice on the formation of such committees and requesting certain doctors to serve on the committees.

Dr. Pollak stated that he was chairman of a special Advisory Committee on Tuberculosis to the Public Health Committee and that this Committee could serve in a State capacity.

Dr. Haggerty moved, seconded and *carried,* that this committee recommend to the Board of Trustees to be brought before the House of Delegates that a Committee on Tuberculosis, and a Committee on Mental Hygiene be appointed.

Dr. Wood asked Dr. Ely if he had given consideration to the *Heart Committee* of the American Heart Association. Dr. Ely replied that Dr. Satchwell had recommended it to the House of Delegates last year.

CRIME CONFERENCE

Dr. Wilkes reported that a conference Crime had been called by Governor Hoffman on March 1 and 2 to take place in the War Memorial Building, Trenton. Dr. Morrison forwarded a letter regarding this to Dr. Ely with the suggestion that he appoint delegates from the Medical Society to attend. Those who have been appointed are Drs. Potter, Morrison, Stone, Molitch, Mitchell, Plant, Curry and Newcomb.

NURSING AND NURSING EDUCATION

The following doctors have been appointed to this Committee: Drs. Satchwell, Condon, and Ill.

Dr. Kraker suggests that the Medical Society has approvde the Nursing Education program with the appointment of such a Committee.

PUBLIC HEALTH COMMITTEE

In the absence of Dr. Nichols, Dr. Wilkes reported on the activities of the Public Health Committee. He stated that activity in some counties is very marked, but not in the State as a whole, although the work is steadily increasing. He urged the improvement of business methods in providing medical services.

MEDICAL ECONOMICS

Dr. Wilkes reported on the meeting on *economics* at Atlantic City on Sunday, January 27, 1935, at which representatives from New York, New Jersey, Pennsylvania, District of Columbia, Maryland, New Hampshire, Illinois were present. (Journal, February, page 106.) Those who attended from New Jersey were Drs. Ulmer, Lewis, Charlton, Sprague and Wilkes. One of the best plans now working is in Washington, D. C., and it is very practical. Discussions at the meeting were as to specific ways and means

by which the Medical Society itself could improve economic conditions and do it by improving the service to the public. The final concensus of opinion among those present was that the A. M. A. should not stop at the announcement of the ten principles, but go further, with full realization that it cannot satisfy every state but *it can draw up a plan* which will give each state a background to work from.

Mention was made that delegates from each State Medical Society should be specifically instructed to request the A. M. A. to provide a plan that could be modified by each state. Emphasis was laid on the fact that the Medical Society of New Jersey felt that the A. M. A. should do this as a part of its obligations to the State Societies.

Dr. Wilkes stated that copies of the analysis of the Wagner Bill and the bill on social insurance of the American Social Security Society had been received in the Executive Offices and copies would be sent to the important committees in the House and Senate of the State Legislature. (Journal, February, page 106.)

HOSPITAL AND MEDICAL EDUCATION

Dr. Ely stated that the Committee on Hospital and Medical Education, Dr. C. B. Kelley, Chairman, had submitted a report on hospitals for three years to the House of Delegates at the Annual Meeting, and each time the report was referred back to the committee for further study.

THE DEPARTMENT OF INSTITUTIONS AND AGENCIES

At a meeting of the Board of Trustees, it was suggested that he get in touch with Commissioner Ellis with regard to the hospital situation in the State. Such a meeting was held on January 22, 1935, with Dr. Wilkes and Dr. Ely representing the Medical Society and Commissioner Ellis the hospitals.

Dr. Wilkes read the following notes of the conference with Commissioner Ellis:

Dr. Ely gave Commissioner Ellis the background of the proceedings underlying the recommendations of the Sub-Committee on Hospitals and Medical Education, Dr. Charles B. Kelley, Chairman. The sub-committee has submitted its report. This committee was appointed in October, 1933, to carry on the work imposed upon a similar committee in June, 1932.

Four recommendations of Dr. Kelley's committee were presented to Commissioner Ellis for his consideration. Discussing each recommendation separately with Dr. Ely and Dr. Wilkes, the Commissioner manifested an attitude which was most favorable toward coöperative efforts between the Medical Society, the Hospital Association, and the Department of Institutions and Agencies.

The Commissioner, out of extended experience and an intimate knowledge of the law as it now exists, pointed out some of the difficulties involved.

I.

He felt that the political influence of religious and fraternal groups had so far been sufficient to prevent the inclusion of non-profit hospitals and especially those conducted under the auspices of fraternal and religious bodies, from being included in the supervision of the Department of Institutions and Agencies. This fact immedaitely becomes formidable in any efforts to include *other* non-governmental hospitals under the supervision of the Department of Institutions and Agencies, because the latter claim that such compulsory supervision would be discriminating in that the religious and fraternally sponsored hospitals are free of such compulsory supervision.

Commissioner Ellis felt that greater progress could be, and in fact is being, made under a voluntary improvement plan in which the assistance of specialists on hospital management (administration, food, construction) is supplied by Commissioner Ellis on request.

Commissioner Ellis also felt that if the Medical Society would provide similar standards by which the professional personnel could be rated or measured, this would provide a distinctly forward step and would be appreciated by some, if not all, of the hospitals.

He suggested that certain of the members of the Medical Society might be appointed in various specialized fields to advise hospital management and boards of trustees on request, and that would be helpful; and this plan would avoid unnecessarily antagonizing the hospital management through an endeavor to obtain what might prove to be impotent legislation.

He felt that the opposition by certain groups concerned could possibly prevent, through political and other influences, the passage of such legislation. In any case, "broadening the act which now gives the Commissioner of Institutions and Agencies control over profit nursing homes" could hardly achieve the desired aims.

Commissioner Ellis agreed that the previous suggestion to provide standards for voluntary ratings might provide a means by which the professional set-up of hospitals could be improved to the satisfaction of the State Board of Medical Examiners.

He agreed that the licensing of profit nursing homes should be based in part on having the professional set-up of such home: agreeable to the State Board of Medical Examiners before the license is issued.

He felt that a joint committee of the representatives of the Department of Institutions and Agencies, the State Medical Society, and the New Jersey Hospital Association could provide rules and regulations approved by the State Board of Medi-

cal Examiners insuring the professional set-up of hospitals and nursing homes as suggested by the Sub-Committee on Hospitals of The Medical Society of New Jersey.

II.

Commissioner Ellis stated that while the formulation of definitions and standards to be recommended by The Medical Society of New Jersey as a basis for determining relationship of its members on hospitals, clinics, and dispensaries was distinctly a problem of The Medical Society, definitions and standards were most desirable from the standpoint of his Department and the hospitals as well.

The practical difficulties involved concerned those physicians who are *not* members of The Medical Society of New Jersey and who incorporate some of the smaller private hospitals as "non-profit institutions", which removed them from the control and supervision of the Department of Institutions and Agencies under the existing law.

The Commissioner felt, however, that even *these* physicians would eventually be forced by public opinion to conform to the standards set and accepted by the better hospitals.

The approval of hospitals for interne training is a matter of medical education (post-graduate) and is already a function of the State Board of Medical Examiners. Such approval for interne training in such hospitals is given by the A. M. A. under certain conditions, and a list of such hospitals is published annually in the A. M. A. report, which shows the approved hospitals.

A comparison of the A. M. A. requirements with those proposed by the State Board of Medical Examiners is suggested. The suggestions considered under the first problem would aid in establishing "the privileges, duties, and restrictions of the medical staff" as suggested in the report of Dr. Kelley's Committee, together with the subjects of "staff meetings, records, laboratory service, and eligibility for free service".

LeRoy A. Wilkes,
Secretary, Welfare Committee.

LEGISLATIVE BULLETIN

CATEGORY "A"

S-134

You are urged to act promptly on bills in Category "A".

A new Physicians' Lien bill, which empounds 25 per cent of the award until the physician's bill is paid. This bill is still in the Judiciary Committee of the Senate where it was introduced on January 28. Conferences are being held by the Medical Society with the Insurance Carriers and the Bar Association in an endeavor to provide a more workable bill than our present physicians' lien law, which is being attacked in the courts and will involve considerable litigation, unless we can provide an agreeable substitute in the meantime.

We, of course, will maintain the present law until S-134 has been passed. Please contact your Senator with regard to this bill, and urge his support.

The members of the Judiciary Committee who now have the bill in their charge are Senators Barbour, Powell, Leap, Durand, and Stout. Senator Leap is our legal advisor and the one who drew up our new Physicians' Lien bill. Senator Stout has always supported us as have Senators Durand and Barbour.

The following is the status of the more important medical bills on March fourth:

S-244

The revised State E. R. A. bill is now law, Chapt. 35. This is included here for your information.

A-28

This bill has passed the Assembly and is in the Judiciary Committee of the Senate. This retains to the State Professional Examining Boards the funds which they collect to be used in the conduct of their business. This should be supported.

A-67, A-68, AND A-69

These bills have to do with the detection of tuberculosis. These bills are sponsored by our President-Elect, Dr. Newcomb, and are worthy of your support.

Please speak to your Assemblymen in favor of these bills, which are now out of committee and ready for third reading and final passage.

A-185

This bill is an endeavor on the part of the Bar Association, through one of its members, Mr. Pesin of Hudson County, to shake loose the Physicians' Lien Law amendment, passed last year, from the original Hospital Lien Law to which it was attached. This act on the part of the Bar Association has for its aim the endeavor to remove the Physicians' Lien from casualty cases, and not, as might seem, to protect the hospitals.

A-185 should be kept in the Public Health Committee until S-134 has been made law. After that time it would be desirable to see A-185 passed.

With Dr. Newcomb, majority leader in the Assembly, and Dr. Bien, Chairman of the

Public Health Committee, in which the bill now rests, we feel fairly safe; but you are advised to warn your Assemblymen of the real intent of this bill and that it should under no circumstances be passed prior to the enactment of S-134 into law.

A-238

This bill, Young, January 28, licenses osteopathic physicians and surgeons, and provides new definitions. Referred to the Public Health Committee, where it still remains. The same vicious attempt to expand the scope of osteopathy since "laying on of the hands" has failed.

A-272

This bill, Cavinato, January 28, allows Boards of Freeholders of counties maintaining county tubercular hospitals to appoint business managers of hospitals, thereby removing the physician superintendent. It should be opposed in its present form. Referred to the Public Health Committee.

"A" bills are the only ones on which you will be advised of the change in status, and on which you will be advised to take immediate action. If you will see your Senators and Assemblymen at once and report to us their attitude on the A bills, we shall be guided as to when to endeavor to bring the bills out of committee.

CATEGORY "B"

A-196

This bill (Bien, January 28) requires swimming pools to be licensed by State Department of Health. January 28, to Public Health Committee. February 11, reported. February 11, read second time. Lost in Assembly.

A-331

This bill, Reinert, January 28, requires County Clerks to provide separate book to record physicians' and hospitals' liens. January 28, to Public Health Committee. Presented only for your information.

CATEGORY "C"

S-253

This bill, Powell, February 11, creates a State Board of Photographic Examiners and regulates practice of photography. February 11, to Judiciary Committee. Still in Committee.

A-89

This bill, Gurk, January 28, provides financial aid for carriers of certain communicable diseases. January 28, to Public Health Committee. Still in Committee.

A-278

This bill, Katzenbach, January 28, permits the State Board of Pharmacy to secure Chancery Court injunctions against habitual violators of the pharmacy act or board rules. January 28, to Public Health Committee. February 18, reported. February 18, read second time. Ready for vote in Assembly.

A-284

This bill, McCauley, January 28, forbids alimony in marital actions where there are no children and the wife is physically able to maintain herself. January 28, to Judiciary Committee. Still in Committee.

A-362

This bill, van Nieda, January 28, allows fifteen-day grace period to January 15th for motor vehicle drivers' license renewals, and fixes $1 renewal fee. January 28, to Judiciary Committee. Still in Committee.

A-366

This bill, January 28, repeals the 1874 act providing a Board of Health and Vital Statistics in Hudson County. January 28, to Public Health Committee. Still in Committee.

BOARD OF MEDICAL EXAMINERS

The State Board of Medical Examiners of New Jersey submits the following report of its activities in enforcing the Medical Practice Act during the past six months:

June 13, 1934—Jules F. Blondiau who was practicing medicine and surgery in the office of the Modern Medical Associates of Jersey City, was arrested, and pleaded guilty to the charge and paid the penalty.

June 26, 1934—Abraham Robinson, a druggist of Jersey City, was tried on a charge of practicing medicine without a license. After hearing the State's case his counsel consented to the entry of a judgment against him without putting in any defense, and paid the penalty.

July 11, 1934—Bascom W. Maxwell, who was connected with the office of the Super-Mind Science in Atlantic City, was found guilty of practicing medicine without a license. An appeal has been taken to the Supreme Court by the defendant.

August 1, 1934—Olive L. Schreibweiss, a nurse of Plainfield, New Jersey, pleaded guilty to the charge of practicing medicine without a license and paid the penalty.

September 5, 1934—Alfred W. Reid, an unlicensed chiropractor of Collingswood, pleaded guilty to the charge of practicing medicine without a license and paid the penalty.

September 6, 1934—V. Leeds Singley, a naturopath of Loch Arbour, New Jersey, was found guilty of practicing medicine without a license.

September 12, 1934—Irvin W. Kirk, whose registration of a medical diploma in the County Clerk's office was revoked by the Board on November 22, 1933, pleaded guilty to a charge of practicing medicine without a license and paid the penalty.

September 17, 1934—Simon Noveck, owner of a drug store in New Brunswick, but not a registered pharmacist, pleaded guilty to a charge of practicing medicine without a license and paid the penalty.

September 25, 1934—William Carl Hirsch, connected with the Church of Inner Truth of Secaucus, New Jersey, pleaded guilty to a charge of practicing medicine without a license and paid the penalty.

October 23, 1934—Anthony Zurawski, who was connected with the Modern Medical Associates of Newark, pleaded guilty to a charge of practicing medicine without a license and paid the penalty.

In October, Minnie Vincent of Asbury Park, who was giving electric treatments, colonic irrigations and prescribing drugs, paid the penalty for practicing medicine without a license.

In December, 1934—Jerry Giffune, who was practicing in the Men's and Women's Medical Office, at 472 Broad Street, Newark, New Jersey, pleaded guilty to the charge fo practicing medicine without a license and paid the penalty.

The following certificates of license have been revoked by the Board for conviction of a crime involving moral turpitude:

Maxmilian Thomas Rauh, M.D., of Richmond Hill, New York.

Charles F. Baxter, M.D., of Paterson, New Jersey.

Malcolm C. Rose, M.D., formerly of New York City.

Samuel R. Lustberg, M.D., of Passaic.

Elizabeth Nagy, Midwife, of Perth Amboy.

You will also find enclosed the decision of the New Jersey Supreme Court in the case of the State Board of Medical Examiners vs. Louis Adler, which was filed on August 16, 1934, and a copy of decision from the New Jersey Court of Errors and Appeals in the case of the College of Mecca of Chiropractic vs. State Board of Medical Examiners of New Jersey which was filed on September 27, 1934.

Very truly yours,
James J. McGuire,
Secretary.

NEW JERSEY SUPREME COURT

State Board of Medical Examiners of New Jersey,

Respondent, | May Term 1934

vs. | No. 407

Louis Adler,

Appellant.

Submitted May Term 1934. Decided

On Appeal from First District Court of Newark.

For Appellant: I. Faerber Goldenhorn,
Abraham Sepenuk

For Respondent David T. Wilentz,
Attorney General,
Robert Peacock,
Asst. Atorney General.

Before Justices Lloyd, Case, and Donges.

PER CURIAM:

This is a case of the State Board of Medical Examiners against one Louis Adler, charged with practicing medicine in violation of Section 10 of the Act to Regulate the Practice of Medicine, P. L. 1894, page 459, in which the defendant was convicted, and from which defendant's appeal is here presented.

The respondent has a motion to dismiss the appeal on the ground that the remedy, if any, was by certiorari. While this motion might well prevail, as it is a statutory proceeding for the recovery of a penalty, the case will be disposed of on its merits.

Adler had an office in which he apparently received patients. He was not licensed to practice nor did he have a doctor's sign displayed or call himself "doctor"; but he undoubtedly, as testified by the witnesses called by the board, diagnosed the physical ailments of these witnesses, prescribed medicines, and charged therefor sums clearly indicating that it was for the advice as well as for the medicine. This, under all our cases, established the practice of medicine within the meaning of the act under such cases as State Board vs. Buettel, 102 N. J. L. 74, and numerous other decisions anterior and subsequent thereto.

It is urged by the appellant that the prosecution was not by a "district attorney", and that no representative of the attorney general's office could conduct the case; this because of the last sentence of the 10th section which says, "it shall be the

duty of the respective district attorneys of the counties of this state to prosecute violations of the provisions of this act." Whether it is the duty of district attorneys (probably meaning prosecutors of the pleas) the right of the Board to prosecute through any other official or attorney it seems to us is not in doubt.

The judgment is affirmed with costs.

NEW JERSEY COURT OF ERRORS AND APPEALS

The College of Mecca of Chiropractic, a corporation, Prosecutor-Appellant. State Board of Medical Examiners of The State of New Jersey, Defendant-Respondent.	No. 12 May Term 1934 Per Curiam

On appeal from the New Jersey Supreme Court, in which the following Per Curiam was filed:

"The writ brings up certain proceedings had by the State Board of Medical Examiners of the State of New Jersey whereat the board adopted a resolution setting out the requirements to be met by a Class A medical college in seeking a license under ch. 184, P. L. 1924, to operate as such a college; but the prosecutor's brief is exclusively an attack upon the statute itself. The summation of the brief is as follows:

"It is respectfully urged that Chapter 184 of the Laws of 1924 should be declared unconstitutional and the action of the State Board of Medical Examiners of the State of New Jersey in fixing such requirements, set aside."

and the approach is by four points respectively as follows: (1) There is no power in the State to compel any privately conducted school to meet any requirements unless the school be conducted in a manner inimical to the public health, public safety or public morals; (2) the Act of 1924, Chapter 184, constitutes an unlawful delegation of legislative authority; (3) the Act of 1924 constitutes unlawful special or class legislation; (4) the Act of 1924 violates Article 14. Section 1 of the Constitution of the United States.

"The statute was under like attack by the prosecutor in State Board of Medical Examiners of New Jersey vs. College of Mecca of Chiropractic, Inc., Prosecutor, 6 Misc. 677, aff. by the Court of Errors and Appeals, 106 N. J. L. 602, on the opinion below. This Court held in that case that the requirements of the statute were just and reasonable regulations; that the legislature was within its rights in passing the act; and that the act 'does not offend against any constitutional provision.' That holding is, we consider, dis positive of all points presented on the prosecutor's brief and, inasmuch as the opinion was adopted by the Court of Errors and Appeals, it stands as an adjudication which this Court will not disturb.

"The writ of certiorari is dismissed, with costs."

For the appellant, *J. Raymond Tiffany.*

For the respondent, *David T. Wilentz, Attorney General, and Robert Peacock, Assistant Attorney General of New Jersey.*

PER CURIAM.

The judgment under review herein should be affirmed for the reasons expressed in the opinion delivered in the Supreme Court.

Endorsed:

"Filed Sep. 27, 1934,

THOMAS A. MATHIS,
Clerk."

THE ART OF PRESCRIBING

This article was prepared and furnished by the Joint Committee on Professional Relations of the New Jersey Pharmaceutical Association and the Medical Society of New Jersey

When the writer of this article taught medical students pharmacy more than twenty years ago at the Medico-Chirurgical College in Philadelphia, he was impressed with the keen interest of the students in the art of prescribing. They had received considerable instruction on the construction of a prescription, but because of their lack of familiarity with drugs and their limited clinical experience, they appeared to be somewhat worried about their ability to write satisfactory prescriptions for all cases requiring them. When a medical student or a physician sees the Pharmacopoeia, the National Formulary, or possibly the Dispensatory, he is awed by the great number of individual drugs listed in these standards and texts. If he should happen to visit the supply room or pharmacy of a hospital, or the prescription department of a well-stocked retail drug store, he is still further impressed with the seemingly endless variety of official and non-official drugs and preparations which are evidently prescribed by physicians at various times. It soon becomes apparent to both student and practitioner that the multiplicity of drugs and preparations is due not so much to the needs of

any individual physician or his patients, but rather to the variety and cases and experiences of medical practitioners, and to the fact that nearly every physician is partial to his own particular group of drugs.

In the days referred to above, it was possible to point out to medical students how some of the most successful practitioners took great pains to write detailed prescriptions, including not only the active therapeutic ingredients, but also flavoring agents, adjuvants, and diluents suitable for the particular drugs prescribed. The art of prescribing, although mastered by few, was practiced by many. One of the products of the Machine Age is the ready-made combination of drugs or preparation of a single drug in a form that is palatable, as well as convenient from the standpoint of dosage. Many physicians consider that the prescribing of such ready-made products relieves them of considerable mental labor and assures freedom from possible incompatibility—the bugbear of the inexperienced prescription writer.

As a matter of fact, the incompatibility factor has been greatly overrated. A physician who is in the habit of prescribing a ready-made preparation containing some specific therapeutic agent may want to add to that ready-made product some other therapeutic agent; and he feels that by simply prescribing the added ingredient with the ready-made product, the job is done. It does not occur to him that the base of the ready-made product, which is not often revealed in the formula, may provide a real incompatibility as far as the added ingredient is concerned. Furthermore, it requires just as much mental effort to memorize trade names of proprietary products or ready-made products as it does to write out a prescription for a combination of drugs in a suitable vehicle.

Palatability is unquestionably an important factor in medication. However, the idea that palatability exists only in prepared medicines is a fallacy. Any physician who is willing to take the time to acquaint himself with the vehicles available for prescribing various types of drugs that have a bad taste, will find in the official standards a variety of such vehicles designed for specific purposes and answering those purposes splendidly.

As an example of the vehicles available, the following are presented for the consideration of physicians who wish to write their own combinations of drugs in liquid form, with every opportunity to adjust their dosage to the specific case and with possible economy:

PALATABLE VEHICLES

Compound Elixir of Almond, N. F.

Alcohol 4 per cent

A colorless, pleasant, aromatic vehicle giving a cherry phosphate flavor to sour medicines. Excellent for variation. Because of its low alcoholic content it is particularly good for salines.

Elixir of Anise, N. F.

Alcohol 4 per cent

A colorless vehicle especially pleasing to the infants.

Red Aromatic Elixir, N. F.

Alcohol 22 per cent

A sparkling red elixir, splendid for a "change" and where a high alcoholic content is required.

Compound of Elixir of Cardamon, N. F.

Alcohol 8 per cent

A colorless elixir effective for preparations with marked taste.

Aromatic Elixir of Eriodictyon, N. F.

Alcohol 15 per cent

A dark-colored elixir with the Yerba Santa flavor—very pleasant.

Aqueous Elixir of Glycyrrhiza, N. F.

Alcohol 3 per cent

A dark-colored elixir of licorice. Very pleasant and particularly good for bitters and salines.

Compound Elixir of Taraxacum, N. F.

Alcohol 27 per cent

A dark-colored aromatic elixir. Especially desirable where a high alcoholic content is necessary.

Compound Elixir of Vanillin

Alcohol 8 per cent

A straw-colored elixir, and one of the most pleasing and desirable of the vehicle elixirs for general use.

Syrup of Cocoa, N. F.

A thick chocolate syrup, very satisfactory for masking the quinine salts and other bitters, particularly the insoluble salts.

Syrup of Cinnamon, N. F.

A syrup vehicle with a flavor which is always acceptable.

Aromatic Syrup of Eriodictyon, N. F.

A dark-colored syrup with a very pleasant taste, particularly desirable for quinine salts and other bitters.

Syrup of Glycyrrhiza, N. F.

A dark syrup, licorice flavor, for masking salines, bitters, etc.

Syrup of Raspberry, N. F.

The most delightful and tasty syrup of the National Formulary, especially acceptable for salines—red color.

Syrup of Thyme, N. F.

A dark syrup, offering a decided change in flavor.

SEASONABLE PREPARATIONS

There is a demand at this season for a good penetrating, analgesic ointment, and a good rubefacient and counter-irritant. Three N. F. formulas which fill these requirements are listed below and can be readily obtanied by prescribing them under their official titles:

Inunctum Mentholis Compositum, N. F.

Compound Menthol Inunction

This is a combination of Menthol, 5%; Methly-salicylate, 10%; in a base of hydrous wool-fat, or Lanolin. It is an excellent penetrating analgesic and should be prescribed under the title "Inunction Mentholis Compositum, N. F.", abbreviated "Inunct. Menthol. Co."

Two rubefacient and counter-irritant ointments which give excellent results are the following:

Unguentum Capsici, N. F.

Capsicum Ointment

This ointment contains 5% of oleoresin of Capsicum in a base of Petrolatum and Paraffin. The ointment may be prescribed under the title "Unguentum Capsici, N. F.", abbreviated "Ung. Capsic." The patient should be cautioned not to rub his fingers into the eyes after applying this ointment.

Unguentum Sinapis

Mustard Ointment

This ointment contains 2 per cent of the volatile oil of Mustard in a base of wax and lard. It may be prescribed under the title "Unguentum Sinapis, N. F.", abbreviated "Ung. Sinap." The patient should be warned not to rub his fingers into the eyes after using this ointment.

These National Formulary preparations are available at all prescription pharmacies in New Jersey.

MEETING OF THE FIFTH COUNCILOR DISTRICT

The annual meeting of the Fifth Councilor District (Cape May, Cumberland, Atlantic, Salem and Gloucester Counties) will be held at the Woodbury Country Club, in Woodbury, on Thursday afternoon, April 18, 1935, at 2 p. m. The Gloucester County Medical Society will be the host.

The speakers will be Dr. Hilton S. Read, of Atlantic City, whose subject will be "This Medical Mess". Also, Dr. E. J. G. Beardsley, whose subject will be "The Opportunities and Responsibilities of the Everyday Practice of Medicine".

Dinner will be served at about 4:30 p. m., immediately following the program. All those in attendance will be the guests of the Gloucester County Medical Society.

The Committee on Arrangements consists of C. I. Ulmer, Chairman; W. J. Burkett and H. W. Wright.

NEWARK EYE AND EAR INFIRMARY

The fifty-fifth anniversary of the founding of the Newark Eye and Ear Infirmary was celebrated on the evening of Wednesday, February 27, in the Essex County Country Club, with over 100 members of the staff and their guests present. The guests were received by the Medical Director, Dr. Wells P. Eagleton, and Mrs. Eagleton.

Addresses on the early history of the hospital and its present work were made by Drs. Marcus Seidman, Fred C. Webner, William M. Brien, S. H. Baldwin, R. H. Rogers, E. A. Curtis, Elbert S. Sherman, William O'Gorman Quinby, Frederic W. Smith, and Dr. J. F. Condon, President of the Essex County Medical Society. A special tribute was paid to the memory of Dr. Charles John Kipp, founder of the hospital, who died twenty-four years ago last month.

NOMINATING COMMITTEE OF THE STATE SOCIETY

Frederic J. Quigley, Past President, *Chairman*

Atlantic County	D. W. Scanlon
Bergen	Arcangelo Liva
Burlington	George T. Tracy
Cumberland	Leslie Myatt
Camden	Thomas B. Lee
Cape May	Clarence W. Way
Essex	Alfred Stahl
Gloucester	E. E. Downs
Hudson	Joseph F. Londrigan
Hunterdon	Samuel B. English
Mercer County	Harry R. North
Middlesex	Robert L. McKiernan
Monmouth	John E. Maher
Morris	Bernard C. McMahon
Ocean	Eugene Herbener
Passaic	Harry S. Willard
Salem	D. W. Green
Somerset	D. S. Renner
Sussex	F. P. Wilbur
Union	S. T. Quinn
Warren	Emory Kraus

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS

	Diphtheria Toxoid	Smallpox Vaccine
County	*Month of January*	*Month of January*
Atlantic	16	4
Bergen	107	41
Burlington	16	8
Camden	7	12
Cape May	2	2
Cumberland	0	1
Essex	233	81
Gloucester	22	3
Hunterdon	7	2
Mercer	2	0
Middlesex	22	23
Monmouth	20	3
Morris	19	59
Ocean	13	0
Passaic	65	109
Salem	1	1
Somerset	77	74
Sussex	287	10
Union	10	0
Warren	2	0
Totals	928	433
Reported prior to Jan. 1	5,007	2,425
Total to Jan. 31	5,932	2,858

OBITUARIES

JOHN E. PRATT, M.D.

Dr. John E. Pratt, of Dumont, New Jersey, died suddenly on February 6 apparently of a heart condition. Dr. Pratt was eighty-four years of age on November 11th last. He was born and bred in New England. He graduated from Dartmouth in the class of 1876 and practiced in Cape Cod, Mass., until 1895 when he came to Dumont. Dr. Pratt was very active in the Bergen County Medical Society in his younger days, and served as President in the year 1903-1904. At one time he served on the Board of the Hackensack Hospital. He retired from active practice fifteen years ago.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING JANUARY, 1935

Supplied by the State Department of Health

Name	Age Yrs.	Date Death	Place of Death	Residence	Cause of Death
Frederick C. Van Vliet	81	Dec. 20, 1934	Shrewsbury	Same	Chr. cardio nephritis
Frank C. Shipman	54	Jan. 4, 1935	Jersey City	Same	Carcinoma base of tongue
Alice M. Conger	62	Jan. 3, 1935	Chatham	Same	Carcinoma of breast

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MARCH			
5	Camden	13	Burlington
5	Hudson	14	Essex
8	Atlantic	14	Passaic
12	Bergen	20	Middlesex
12	Sussex	21	Gloucester
13	Mercer	21	Morris
13	Ocean	27	Monmouth

APRIL			
2	Camden	11	Passaic
4	Hudson	11	Somerset
9	Cumberland	12	Atlantic
9	Bergen	16	Warren
10	Mercer	17	Middlesex
10	Ocean	18	Gloucester
10	Salem	23	Hunterdon
10	Union	24	Monmouth
11	Essex		

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, February 9th, 1935, at 8.30 p. m. at the Hotel Claridge, Dr. C. C. Charlton presiding. One hundred and ten members and guests were present.

The minutes of the January meeting were read and approved.

Dr. H. S. Davidson, reporting for the Board of Censors, stated that the applications of Dr. J. A. Henry for active membership and Dr. E. C. Wescott for associate membership had been approved. The applications of Drs. J. C. Bitler, of Hammonton, and Dr. Willard Mason, of Atlantic City, were not approved and no action had been taken on the application of Dr. Henry Ruffo.

Drs. Henry and Wescott were elected.

E. R. A.

Dr. J. S. Irvin reported for the Medical Advisory Committee that the law governing the E. R. A. was supposed to have been automatically ended on February 1st but it has been continued for one more month by emergency legislation but will be automatically ended unless the Legislature takes action. They have not passed a law concerning the E. R. A. because Congress has not yet passed the proposed Work-Relief legislation. Probably there will be more of a burden on states and municipalities than in the past (page 160).

There has been some criticism from the State authorities about medical relief here in Atlantic County. They think too much is being spent.

In order to cut this expense here, Mr. Cross suggested that we employ a physician to sit in the Atlantic City office of the E. R. A. to pass on the patients as to whether they are really in need of medical treatment because many of them are not very sick and probably all they need is some simple remedy. If the physician would dispense these at the office, it would save the State money. This will really mean a State Clinic, and Dr. Irvin said he thought the Society should take some definite action regarding it.

There was a great deal of discussion by the members on the subject, and the final outcome was a motion that the Secretary write to Mr. Cross stating that this Society as a whole was unalterably opposed to any such plan as being very poor medical practice.

Dr. W. P. Conaway stated that a meeting of the A. M. A. to oppose this sort of practice being made legal was to be held in Chicago next week at which he would be present and would make a report at the next meeting of this Society (page 157).

LEGISLATION

Dr. Allman, reporting for the Legislation Committee, stated that no new measures were coming up except defensive programs this year.

The Lien Law is being attached and some rearrangements are to be made and a compromise will be satisfactory if within reason.

Dr. Allman stated that if there were any matters of interest that were coming up, the physicians should be interested enough to take a stand either for or against them as the case might be. He mentioned a bill coming up which would put the osteopaths on the same basis with the physicians, and a petition being circulated among the firemen and policemen of this city which is to be sent to the Legislature.

He said he believed the physicians should do something about this—that we should write to our three legislators and state that we were unalterably opposed to it.

Dr. Silvers said that a bill had been introduced on January 29th with regard to the Lien Law. The physician's lien comes before the lawyer's lien. Only three counties succeeded in getting the law working.

The new bill does away with the fee schedule and the charges shall be rendered and become a lien upon a basis of our regular fees in the vicinity and not more than 25 per cent of the total award.

GRADUATE EDUCATION

Dr. W. J. Carrington, reporting for the Post-Graduate Education Committee, stated that a series of six lectures by one lecturer had been arranged. The lecturer is to be Dr. J. A. Kolmer and the subject, "Recent Advances in Clinical Medicine". The lectures will be held in the Hospital Class Room and the cost $10.00.

Dr. H. S. Subin, reporting for the Entertainment Committee, stated that the dinner for Dr. Kolmer had been attended by thirty-seven members and had been a distinct innovation.

PUBLICITY

Dr. S. Barbash, for the Publicity Committee, said that the new Bulletin was under the direction of Dr. R. A. Kilduffe, and that Dr. B. H. Timberlake was acting as a reporter and he was seeing that what went into the newspapers was correct.

Dr. Charlton stated that the advertisements in the new Bulletin made its publication no expense to the Society.

BROADCASTING

Dr. Read again called the attention of the members to the Broadcasting Program:

Feb. 5—Dr. S. L. Salasin, Health Officer, Atlantic City.

Feb. 9—Dr. LeRoy Wilkes.

Feb. 12—Dr. Philip Marvel, Jr.: The History of Cardiology.

Feb. 16—Dr. J. M. Kuder: The Business of Health.

Feb. 19—Dr. C. M. Fish: The History of Tuberculosis in the U. S.

Feb. 23—Dr. H. Sheridan Baketel, Editor, Medical Economics: Medicine Undermines Its Future.

Feb. 26—Dr. R. A. Kilduffe: Romance and Research.

Mar. 5—Dr. W. E. Darnall: The State Medical Board.

Mar. 12—Dr. S. Barbash: Atlantic County Medical History.

Mar. 19—Dr. V. E. Johnson: The History of Anesthesia.

Mar. 23—Dr. R. P. Fischelis, President the American Pharmaceutical Assn.: The Progress of Pharmacy in the Last One Hundred Years.

Mar. 26—Dr. H. L. Harley: The History of Ophthalmology.

During the coming A. M. A. Convention in June a fifteen-minute daily broadcast will cover the highlights of each day's activities.

It is hoped that if this new policy proves effective the example thus set may be followed by other societies to the ultimate benefit of the profession at large.

While the "education of the public (?)" has proceeded apace by means of the radio, it must be conceded that the usual medical broadcast is under a heavy handicap when competing with the radio bands and varied forms of entertainment which form the setting for the commercial miseducation of the public which nightly blares forth from millions of loudspeakers.

Physicians know, as the public does not, that many of these purely commercial programs are submerged in an ocean of quackery; and appreciate also the anonymity of the "eminent physicians" and "outstanding institutions" made to sponsor the often absurd claims of a host of medicinal and pseudomedicinal products.

The Broadcasting Committee of the Atlantic County Medical Society has therefore inaugurated a new type of program which it is hoped will attract interest.

Instead of the usual medical program of "health talk", the series will present the broader, more interesting, and even more dramatic aspects of medicine, such as simple sketches of medical pioneers, and descriptions of important discoveries.

Two excellent fifteen-minute "spots" have been secured through the courtesy of the Director of Station WPG Tuesday afternoons at 5 and Saturday evenings at 8.15.

These periods are peculiarly free from chain competition.

The Tuesday broadcast will be given by members of the Atlantic County Medical Society and other prominent speakers, while eminent out-of-town speakers will be heard on Saturday evenings. These, through the courtesy of Haddon Hall, will be entertained with their families over the week-end.

A. M. A. ANNUAL MEETING

Dr. W. J. Carrington stated that the personnel of the committees for the A. M. A. Convention could only be composed of members in good standing in the County Society and as numerous members had not yet paid dues he could not make up these committees.

DUES

Dr. Charlton urged all those members who had not paid their dues to please do so in order that everyone would be in good standing.

Dr. Allman stated that not two-thirds of the members had paid their dues for 1935. The deadline was really set at February 1st, but an extension was granted to five days before the first of March. If the County Society dues are not paid by that time, membership ceases in the State Society and A. M. A.

The following motion by Dr. H. S. Read concerning the payment of dues was duly seconded and unanimously carried:

Motion: That the Treasurer be authorized:

a. To cancel all unpaid dues prior to 1934;

b. To accept for 1934 dues, the payment of which is mandatory, either cash; or at the discretion of the Board of Censors, a non-interest-bearing note;

c. To accept for 1935 dues, $13.00 in cash covering the State assessment, and to accept the remaining $5.00 in monthly installments.

HONORARY MEMBER

Dr. Allman proposed that Dr. M. S. Ireland be made an Honorary Member of the Society; and after the proper motion was passed he was placed on the roll of honorary members.

NEW SEAL

Dr. H. L. Harley brought the new seal to the attention of the members and stated that an amendment to the Constitution and By-Laws was necessary for it to be made the official seal of the Society and a motion was passed that this be done. The following amendment was proposed:

Article X: Seal.

The Seal adopted at a regular meeting of the Society held February 8th, 1935, and shown herewith, shall be the Seal of the Atlantic County Medical Society.

SCIENTIFIC

The Scientific Program was presented by Dr. John A. Kolmer, Professor of Medicine at Temple University, Philadelphia, whose paper was entitled "Infection, Susceptibility, and Vaccination in Acute Anterior Poliomyelitis". The discussion was opened by Dr. R. A. Kilduffe and Dr. H. S. Davidson.

Dr. Charlton announced that the March meeting would be held at the Hotel Dennis and the Scientific Program is to be presented by Dr. Pol N. Caryllos, Professor of Thoracic Surgery, Cornell University Medical School, on the Pathogenesis, Mechanism, and Treatment of Tuberculous Cavities. The discussion will be opened by Dr. L. H. Clerf of Jefferson Medical College and Dr. Clyde M. Fish.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Holy Name Hospital on Tuesday, February 12, and was called to order by Dr. David Corn, President.

The minutes of the annual meeting held in January were read and approved.

The President called attention to the Executive Committee minutes which were printed in the Bulletin.

The following were elected to membership:

Junior:

Dr. Christian P. Segard, Leonia
Dr. Ross Vilardo, Jr., Garfield
Dr. John B. Mauro, Teaneck

Associate:

Dr. A. P. Randazzo, Garfield

The following applications for membership were read:

Junior:

Dr. Arnold A. Zacchino, Palisade
Dr. Frank S. White, Teaneck
Dr. Charles Tudor, Bogota

The following communications were mentioned:

A letter from the Board of Freeholders requesting the Bergen County Medical Society to submit the names of five physicians in the eastern part of the county, from which the name of one will be chosen to serve on the Board of Managers of Bergen Pines.

A letter from Dr. A. P. Randazzo, of Garfield, announcing the schedule of office hours for the Administration of Diphtheria Toxoid. The schedule is to be printed and given out to the people of Garfield through the doctors' offices and through the Board of Health.

A letter to Dr. F. S. Hallett from the Way Agency stating that the Insurance Company rejected his application for quarter-rate insurance on the basis that there are two cars with three drivers. Dr. Hallett stated that he wanted to call the attention of the members to this fact.

SCIENTIFIC

The meeting was then turned over to Dr. David Goldberg, Chairman of the Scientific Program, who introduced the following three speakers: Dr. Jesse Bullowa, Attending Physician, Harlem Hospital and Willard Parker Hospital; Dr. Alvan LeRoy Barach, Assistant Physician, Presbyterian Hospital, and Dr. Ralph F. Harloe, Assistant Surgeon, Long Island College Hospital and Kingston Avenue Hospital.

Dr. Jesse Bullowa showed a "Film on the Management of Pneumonia" and accompanied it with a very instructive talk; bringing out the remarkable advances in the treatment of pneumonia brought about by the early diagnosis of the type, and by the early administration of antitoxin for Type I and II pneumonias. The organization and team work of a group working on pneumonia was shown to be important. Efficiency and skill were shown in the bacteriological part of the work in typing the sputum and lung suction specimens by the Neufeld and Sabin methods, also in the determination of the development of immunity in the patient by the demonstration of the presence of agglutinins in the patient's blood.

Dr. A. L. Barach gave an illuminating talk on the "Use of Oxygen in Pulmonary Cardiac Disease", emphasizing the advantages of early and prolonged administration.

Dr. Ralph F. Harloe spoke on the "Treatment of Empyema", referring particularly to the closed method of dralnage. By numerous lantern slides he demonstrated the successes he had had by using this method.

Many questions were asked and answered, after which the meeting was adjourned for refreshments.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

President John F. Condon presided at the regular meeting of the *Essex County Medical Society* held at the Academy of Medicine, Newark, Thursday evening, February 14, 1935. The meeting was devoted to the business of the Society and to consideration of the extensive activities of its various committees.

POLIOMYELITIS COMMITTEE

The Poliomyelitis Committee, Dr. R. N. Connolly, Chairman, reported that an Infantile Paralysis Prevention Center, using the Park-Brodie devitalized virus, was proposed and would shortly be established at the Babies' Hospital, Newark, if such an activity was endorsed by the Essex County Medical Profession. After Dr. Wherry, Director of the Babies' Hospital, and Dr. Samuel A. Goldberg, who was formerly associated with Dr. Brodie, spoke on the proposed center, its establishment was endorsed by the County Society.

Notable features of the proposed plan for the prevention center are: application for immunization must be made through the family doctor, the patient will be kept under the family doctor's observation and control and the direction of the Centre will be an official activity of the County Society.

HOSPITALS

Dr. E. W. Sprague reported for the Hospital Committee offering the following principles, the results of considerable study, which were wholeheartedly endorsed by the Society:

1. The poor should received adequate medical care.

2. Essex County must have adequate clinics for the indigent.

3. Referring to the survey of the Hosptial Committee of last year, Essex County has adequate clinics for the indigent.

4. This committee declared that it is a right and a duty of the medical profession to determine for itself what individuals, institutions and organizations have a claim upon physicians for gratuitous services.

5. We urge again the establishment of advisory officers from the medical staff to work jointly with the Social Service and Executive Departments of the hospitals.

6. The committee recommends the adoption by the hospitals in Essex County of the following card to be sent to each referring physician when the patient leaves the hospital:

———— Hospital

Name . . . . . Division . . . .

Address . . . . . .

Was Discharged on . . . . . .

This patient is referred to you for further treatment. If you desire any other information, call at the hospital any day except Saturday afternoon or Sunday, or write the Medical Director.

. . . . . , Medical Director

7. The Committee urges the Medical Staff in the hospitals to follow up the county membership of the Staff members, to check it annually and to contact each staff member who is delinquent from the County Society and act on each case individually.

It was pointed out that after a study of 1000 consecutive unselected applications to a New York City Hospital for free medical care, less than 60 per cent were found to be of the bona fide clinic type, really unable to pay for treatment.

BUSINESS BUREAU

Dr. James H. Lowrey reported the Economics Committee's study of the establishment of a Business Bureau for collection of delinquent accounts. A questionnaire has been sent to all members in an effort to secure pertinent data.

Dr. Irving Fort explained the present status of the Physicians' Lien Law, answering many questions about it.

GRADUATE EDUCATION

Dr. H. H. Satchwell announced the Instruction Program would include three lecture courses on the following subjects: Gross and Microscopic Pathology, Applied Neurology, and Applied Physiology, scheduled to begin late in March.

Dr. R. H. Dieffenbach, Chairman, recommended the establishment of a permanent commission to study and correlate the problems relating to the care and prevention of lung diseases, composed of County Society members. He outlined in detail its plan of organization, purpose and policy.

The Heart Commission reported its activities and invited the whole medical profession to its sessions which are held at 8.30 the last Monday evening in each month at the Academy of Medicine, Newark.

DIPHTHERIA IMMUNIZATION

Urging the Diphtheria Immunization Work, the members were asked to remember their obligation to every infant with whom they had any contact, and to see that the infants were immunized at about the time of its first birthday, certainly well before they reach their second birthday. Diphtheria immunization is a problem of infancy.

Excellent help by the Women's Auxiliary was reported in organizing the profession for the immunization campaign. They determined by questionnaire the one most favorable Public Health Hour for the greatest number of doctors in an effort to have the same public health hour observed by the profession. Over 400 physicians replied, 50 per cent preferring Tuesdays, 1 p. m. Next in preference were Tuesdays, 3 p. m., and Mondays, 1 p. m. The Women's Auxiliary printed and distributed 6000 ethical letters and distributed the health hour cards for physicians' windows. The Women's Auxiliary workers also collected unmailed doctors' reports and old toxoid. This coöperation by the ladies was commended and keen appreciation expressed.

HEALTH INSURANCE

Dr. Sprague spoke on Health Insurance and urged all physicians to exert themselves to educate the public against health insurance.

The following new members were elected:

Regular:

Pellegrino D'Acuto, 141 Prospect Avenue, Newark

Louis Martucci, 192 Mt. Prospect Avenue, Newark

Edwin C. Mick, 154 Main Street, Orange

Associate:

Anthony R. Caputo, 15 DeWitta Avenue, Belleville

Marguerite Kingsbury, 207 Summer Avenue, Newark

Sigismund John Ostrowski, 194 Broad Street, Bloomfield.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Adrian Ralph Kristeller, D.D.S., Secretary

It had been felt that the Academy had progressed to the point where a revision of its Constitution and By-Laws was necessary. A committee, consisting of Dr. William Gauch, chairman; Dr. P. DuBois Bunting, Dr. Roger W. Moister and Dr. Ralph Waldron, was appointed to accomplish this result. After many months of work they submitted a revised Constitution.

The stated meeting in December was devoted to the passage of the revised Constitution and By-Laws.

There was a change in the standing committees, thereby increasing their scope and membership, so that it is now obligatory to have men who reside outside the City of Newark on these committees.

THE IRVINGTON PHYSICIANS ASSOCIATION, INC.

The physicians of Irvington, Essex County, have formed *The Irvington Physicians' Association*, whose objects and purposes are:

1. To safeguard the best interests of the medical profession in order to prevent exploitation of the profession by any group or individual;
2. To correct certain abuses that are constantly being imposed upon them;
3. To familiarize their townsfolk with the necessity for retention of the doctor-patient relationship and the dangers ensuing directly from its dissolution;
4. To promote and further the professional, business and social interests of its members;
5. To inculcate a spirit of helpfulness and good fellowship among them, and to provide for them economic security.

At the annual meeting held February 19th, the following officers were elected:

President, J. F. Lowell.
Vice-President, E. W. Mierau.
Secretary, William Weinstein.
Treasurer, A. T. Lippard.
Trustee (3 years): R. Y. Hubbard.
Trustee (2 years): H. H. Satchwell.
Trustee (1 year): I. B. Rothstein.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* met on the evening of February 21 in the Hotel Pitman, in Pitman.

The members sent their sympathy to Dr. Charles D. Pedrick, of Glassboro, and their wishes for his prompt recovery from illness.

Dr. Edward Rose, of the Medical School of the University of Pennsylvania, gave an illustrated lecture on "Recent Advances in Endocrinology".

At the close of the meeting, the members joined with the Woman's Auxiliary in a buffet supper.

The members present were: Drs. William E. Crain, Duncan Campbell, H. B. Diverty, William Brewer, Fuller G. Sherman, E. E. Downs, Dorothy Rogers, Ralph Moore, C. A. Bowersox, J. Harris Underwood and Paul M. Pegau, of Woodbury; C. I. Ulmer, Gibbstown; Don Weems, Wenonah; William Pedrick, Glassboro; E. L. Ristine and R. K. Hollinshed, Westville; I. W. Knight, W. J. Burkett and M. F. Lummis, Pitman; C. C. Sheets, Oran A. Wood and H. L. Sinexon, Paulsboro; A. B. Black, Mickleton; H. W. Wright, Williamstown; T. M. Gairdner, Gibbstown; Frederick G. Wandell, Clayton. Dr. Oram R. Kline, of Woodbury, attended as delegate from the Camden County Medical Society.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, February 5, 1935, at the Cartaret Club. The meeting was called to order at 9.15 p. m.

The first order of business was the scientific session at which Dr. Frank Lahey, of Boston, Mass., gave a paper on "Some of the New Developments in Thyroid and Parathyroid Diseases".

LEGISLATION

In regard to State Legislature Bills, namely S-134, S-244, A-28, A-67, A-68, A-69, A-185, Dr. Schwartz moved that the society through the Legislative Committee support the action of the Medical Society of New Jersey in having these bills passed. Dr. Shapiro seconded the motion and it was adopted.

ELECTRICITY RATES

Dr. Abram Weiss brought up the question of increased electric rates where doctors have their homes and offices combined. Dr. Weiss explained that the Public Service Company has taken the doctors off the residence rate and put them on the general rate because where a doctor uses more than two rooms for an office it is considered a place of business. The speaker said that some men don't realize that they are being charge 40 per cent more for their electricity as they are paying the general rate for their residence unless they have put a separate meter in for their office.

Dr. Shapiro moved that this matter be referred to the Welfare Committee. Dr. Higgins seconded the motion and it was carried.

PUBLICITY COMMITTEE

The Publicity Committee reported that the Red Cross insignia for the automobiles of doctors are ready for distribution, the charge for two being 90 cents. There is a supply of 220 plates at present. There is no doubt that the use of these insignia will create a certain amount of publicity favorable to the physician. We hope to report to you by our next meeting on what special concessions the police departments will agree to extend to doctors while making sick calls. Our aim is to have the police department concede to a thirty-minute parking privilege in restricted areas.

RADIO AND NEWSPAPER

The Publicity Committee was authorized by the Society to arrange for publication in the newspapers of the medical talks which are being presented by our doctors on the radio broadcast program. The newspapers regard the radio as their chief competitor and they have a rule of the Press Association which forbids the publication in full of any radio talk. However, these newspapers are ready to publish medical articles written by members of this Society provided these articles are not the same as were given over the radio but were prepared only for publication in the newspaper. The Publicity Committee feels that the doctors would benefit greatly through the presentation of talks in the newspapers sponsored by the Hudson County Medical Society. We have not gone any further in this matter up to this time.

Dr. Thomas Higgins, Chairman of the Publicity Committee, has sent the following appeal to the members of the Society:

"The Society has presented thirty-nine radio talks up to this time. There is considerable favorable response from the public, and the committee feels that its efforts are well worth while. It is unfortunate that the doctors of this Society have

not taken a little more interest in this matter. In spite of the fact that we mailed a placard to every member of the Society, many of our members do not know how many days we are on the air nor the time of the day that we broadcast. Some do not even comprehend that the three-day-a-week broadcast by the Hudson County Medical Society is something entirely different from the one-day-a-week program being presented by the Hudson County Board of Health. This lack of interest by our own members accounts for the failure of many programs undertaken by this Society.

If you feel that the Publicity Committee is doing its work well, express this feeling by volunteering to talk on one of our broadcasts. This is not asking very much of you, and it will lessen the work of the Publicity Committee a great deal."

DINNER COMMITTEE REPORT

Dr. Schuck, Chairman of the Dinner Committee, whose members consist of Drs. George Sullivan, of Hoboken; Thomas Higgins, Nicholas Alter, of Jersey City; M. J. Weiss, of Bayonne, and Charles Niemeyer, of Union City, informed the Society that the date for our Annual Dinner is March 2, 1935. The place—Meyers Hotel in Hoboken. The price—Three dollars ($3.00) per ticket. Tickets will be mailed to members individually. There will be entertainment. It is urgently requested by the Dinner Committee that the Society as a unit get in back of this committee and make this the biggest dinner the Society has had to date.

NEW BUSINESS

Dr. M. Shapiro stated that there is a group in Bayonne that need financial aid and they thought they could get it from the E. R. A. We would like to know what the attitude of the Society is in regard to the E. R. A.

Dr. Chapman said that the Society has taken action on this twice before. "I can't make any suggestions at the present time," he said. "I think that it should be referred to the Economics Committee."

Dr. Marshak moved that the matter of the E. R. A. be referred to the Economics Committee. After considerable discussion by Drs. Maras, Shapiro and Waters the matter was so referred.

Meeting adjourned at 11.45 p. m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on the evening of February 13, President Cottone presiding.

Dr. I. P. Davenport was elected to active membership, and Drs. J. S. Kondor and G. N. J. Sommer, Jr. were elected to associate membership.

President Cottone made a very earnest appeal for the support of the "Public Health Hour", while Dr. Atkinson reported progress on the part of the Maternal Welfare Committee.

Dr. Sommer called the attention of the members to their lack of interest in the progress of the Physicians' Lien Law, and made an emphatic exhortation for representation at the hearing to be held February 21.

The amendment to the By-Laws relative to associate membership was unanimously adopted.

Following the usual diversified discussion surrounding the subject of the E. R. A., the motion was made and carried that the Medical Director of each of the Hospitals be authorized to confer with the County Advisory Committee relative to Emergency Relief work in the Hospitals.

Following the consideration for recommendation for inclusion on the E. R. A. approved list any Physician, other than full time Municipal, County or State Employees, the motion carried that the Society approve all such Physicians.

SCIENTIFIC

Dr. Francis C. Grant of the University of Pennsylvania was introduced and delivered a most interesting and instructive lecture, on the subject. "Diagnosis and Localization of Tumors of the Brain", illustrated with slides.

The renowned reputation of Dr. Grant in this field of medicine is such that, to fully appreciate his elucidation relative to this profound study, one must have heard him speak.

MIDDLESEX COUNTY

Karl Rothschild, M.D., Reporter

JANUARY MEETING

The monthly meeting of the *Middlesex County Medical Society* was held at "The Pines" on Wednesday, January 16, 1935, and presided over by Dr. Harry Haywood, President.

The President informed the society that his list of appointments was not completed at this time and that he is going to reappoint the chairmen of the committees whose programs have not been completed.

On motion of Dr. Marks it was passed by the society to rescind the action taken by the society whereby delegates were elected for a period of one year and that only the three year term delegates should be considered elected.

DUES

The treasurer, Dr. Marshall Smith, read a letter received by the treasurer of the State Society, to the effect that the dues of the Middlesex County Society should be paid at this time, and that the County Society was to be responsible for the dues of all its enrolled members. Dr. Smith then gave a survey of the delinquencies, viz: 19 for 1935; 8 for 1934; 4 for 1933, and 1 for 1932. A motion was finally passed that the delinquent members be given until April 1, 1935, to pay the dues or be dropped from the roll.

The Secretary read a letter of resignation from his office as reporter, received by Dr. G. F. Hilker. The resignation was accepted by the society and upon motion, Dr. Karl Rothschild of New Brunswick was unanimously elected reporter for the year 1935.

E. R. A.

Dr. Wilentz, for the Arbitration Committee, informed the society that the new E. R. A. plan is working in Perth Amboy and Woodbridge at the present time, and that Dr. Fithian is going to

call a meeting in New Brunswick in order to establish the new plan in that community.

PRESIDENT'S PLANS

The President then gave an outline of his plans for the present year and stated that he wished to consider the business side of the profession and advised the doctors to enter the political arena to gain their objectives. In this plan he asked for the support of every man. In particular he proposed:

1. The organization of a *Woman's Auxiliary*...
2. A definite attitude of the doctors towards chain stores and other establishments who send their employees to physicians and institutions in larger centers rather than take advantage of the local medical facilities.
3. Some form of legislation which would permit a judge to render a directed verdict in malpractice suits against doctors where the plaintiff drops the suit at the time set for the trial.

The President then announced that he was appointing a committee to report on an organization of a Woman's Auxiliary at the next meeting.

DR. ELY'S ADDRESS

The President then introduced the speaker of the evening, Dr. Lancelot Ely, President of the State Medical Society. Dr. Ely gave a very comprehensive outline of the activities of the State Society in which each individual doctor should be especially interested. He discussed in particular the problems of the Welfare Committee, involving the encroachment by lay organizations, the difficulties in handling hospital clinics, and the Public Health Hour plan. He mentioned that it is planned to install *pre-school examinations* in the doctors' offices. He felt that the school superintendents are generally coöperative, especially since Dr. Ireland has invited their coöperation. He further told that Dr. Levy recommended payment for physicians on Public Health Stations.

Dr. Ely then talked about the important tasks that could be solved by the Woman's Auxiliary through their membership in various women's organizations. He reported that a plan is on foot to consolidate the allied medical professions (physicians, dentists, pharmacists and nurses) in a conference, with the object to aid one another in legislative work. Dr. Ely also spoke of the problems provoked by the Physicians' Lien Law inasmuch as the Bar Association is opposed to certain features of it.

The E. R. A. presents a grave problem in New Jersey, In 1934 a million dollars were spent in this state on doctor's fees and the State Medical Society has advised the continuance of the same plan for another year.

Dr. Ely then reported on the recent conference of Social Workers held in Asbury Park. He said there is a strong feeling in the minds of the public that different methods of paying the doctors should be instituted. A letter was written to the President in Washington, as well as to Senators and to the Secretaries of the Interior and of Labor, warning against hurried legislation in this respect. A social group has sent bills to 43 states which would involve all the worst that is in the English and German insurance plans. Dr. Ely advised the physicians not to sign up with any lay organization for a salary.

Dr. Ely closed his remarks with an appeal to the physicians to read the State Journal in order to be conversant with the newest developments in all fields.

Following Dr. Ely's discussion the President expressed the thanks of the society. The meeting closed with no usual supper, uniting the members in social conversation and discussion of the various problems.

FEBRUARY MEETING

The regular monthly meeting of the *Middlesex County Medical Society* was held at the "Pines", Metuchen, on February 20, 1935, Dr. Haywood presiding. The minutes of the last meeting were presented by the reporter.

VISITING NURSES

Secretary Taber read a letter received from J. L. McGuire, Secretary of the State Board of Medical Exeminers. This letter is of fundamental importance. It bears out the opinion of doctors that nurses are not entitled to make first calls on patients and decide whether a physician should be called or not. The letter states that the Visiting Nurses Association has been informed about the word and spirit of the Medical Practice Act and that individual nurses will be prosecuted if they do not abide by the laws. It was brought out in remarks by Drs. Rowland and Sherman that this evil is not only prominent in New Brunswick but throughout the State and even a national problem. The Metropolitan Life Insurance Company supplies its policy holders with nurses' care. In the future, they shall not be allowed to make first calls, and any attention paid by them to a patient must be under the direction of a physician. The merit to have brought this state of affairs to the knowledge of the proper authorities belongs to the Medical Section of the Rutgers Club in New Brunswick.

Dr. Rothschild recommended that the Club to consider further the encroachment in the physician's prerogatives by factory nurses who actually practice medicine, and also the fact that factories send injured workmen to hospital clinics, to be treated by non-licensed internes.

E. R. A.

The Medical Advisory Committee presented the following problems and recommendations:

1. It is recommended that the sum of $250.00 shall be the maximum receivable by an individual physician from the E. R. A. per month. A motion to this effect was seconded and carried.

2. It is recommended to include in the list of physicians approved by the E. R. A. every physician other than full time municipal, county, or state employees. The motion was unanimously adopted.

3. Eye glasses can be prescribed only for students, and for persons who would be prevented from obtaining a job or would lose a position unless so provided.

4. Roentgenological work should be referred to private physicians rather than to hospitals.

There was a lively discussion about the advisability of developing a special formulary for E. R. A. cases. Opinions ranged from hearty approval, as by Dr. Rowland, to skepticism about its efficiency as by Dr. Marks.

Immunizations

Dr. Mann reported for the Public Health Committee that the County School superintendent has been approached and that a meeting with him has been arranged to continue the immunization program in the County.

Scientific

The guest speaker, Dr. Henry Barkhorn, of Newark, N. J., entertained and enlightened the society with a paper on "The Common Problems of Eye, Ear, Nose and Throat Practice", which was a masterpiece in presentation and contents. It was discussed by Drs. Sullivan, Howley and Mann.

The Journal

The spirit of the meeting encouraged Dr. Barkhorn to talk on his problems as Chairman of the Publication Committee, and he succeeded so well that the Journal will from now on be forgiven all its shortcomings.

On motion the meeting adjourned at midnight.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

Executive Committee

A meeting of the Executive Committee was held at the Fitkin Memorial Hospital on January 7, 1935, with the following men present: Doctors Fairbanks, Fisher, Holters, Parry, Nichols, Blaisdell, Herrman, MacKenzie and Featherston.

The Secretary was instructed to write to the State Board of Education to obtain the ruling on the right of school physicians to prescribe.

E. R. A.

In accordance with a decision reached at the annual meeting of the County Society, the State and County Chairmen of the E. R. A. were notified that Monmouth County Medical Society would withdraw from its agreement unless at least one doctor was included on the County E. R. A. Council. Dr. Spencer Snedecor, Chairman of the State Medical Advisory Committee to E. R. A., advised that his Committee was arranging conferences with Governor-elect Hoffman and Senator Wolber in an effort to make mandatory the inclusion of physicians on the County Councils. He requested that our Society do nothing at present. It was moved and seconded, that we commend the State Society on its action and await developments.

Dr. Nichols suggested a plan for the administration of medical care to those on relief, whereby the County Society would receive directly the funds set aside for those people and be responsible for the administration of these funds and the direction of the entire health program for the County. It was felt that such a plan could be worked out if it were acceptable to the State E. R. A. It was moved and seconded that the matter be referred to Dr. Herrman, Chairman of the Economic Committee, for further investigation.

January Meeting

The January Meeting of the *Monmouth County Medical Society*, postponed from January 23, was held in the Auditorium of the Jersey Central Power and Light Company, Allenhurst, on Wednesday evening, January 30, at 8.30 o'clock, with President Dr. W. H. Fairbanks in the chair.

The minutes of the annual December meeting were read and approved and the recommendations of the Executive Committee were accepted.

Dr. Herrman tendered his resignation as delegate to the State Annual Meeting. The resignation was accepted.

The following delegates and alternates to the Annual Meeting were elected:

Delegates	Alternates
Dr. John E. Maher	Dr. Frank Altschul
Dr. D. M. P. Magee	Dr. Samuel Edelson
Dr. James P. Pregnall	Dr. Joseph Wiener
Dr. Martin A. Quirk	Dr. Joseph G. Villapiano

The following additional members were elected to the Executive Committee:

Dr. Harold A. Kazmann
Dr. Charles E. Prout
Dr. James P. Pregnall
Dr. George H. Hunt

The following applications for membership were received:

Dr. C. P. Bailey, Lakewood
Dr. M. J. Lorenzo, Red Bank

Dr. Julius Torren, Marlboro, was elected to membership.

Insurance

A communication was received from a representative of the Massachusetts Protective Association requesting permission to present its plan for accident and health insurance. It was voted that the request be granted, and the Secretary of the Society was instructed to obtain information from the State Banking Commissioner in regard to the reliability of the Insurance Company.

Incorporation of the County Society

In order that the individual members of the Society might be protected, it was moved and seconded that the Monmouth County Medical Society be incorporated, the five trustees to be chosen from the Past Presidents of the Society. The vote was unanimous.

Physicians' Lien Law

Dr. William G. Herrman advised that groups representing the State Bar Association and the Insurance Companies threatened to delay the Phy-

sicians' Lien Law by means of a writ of certiorari. It has been suggested that in place of this law, another be enacted, whereby 25 per cent of the sum of money to be paid to the injured in liability cases be set aside until the physicians' bill was paid. Dr. Herrman requested that he be instructed how to vote at the next meeting of the Physicians' Lien Law Committee, at which time it will be decided whether or not to attempt enactment of new legislation along these lines. It was voted that Dr. Herrman should attend the meeting without instructions, in order that he use his best judgment in the interests of the Society.

SCIENTIFIC

Following the business session the Meeting was turned over to Dr. Victor Knapp for the presentation of the scientific program. Dr. I. W. Held, Attending Physician, Beth Israel Hospital, New York City, read a very comprehensive paper on "Atypical Gall-Bladder Disease", laying special stress on the symptomatology and pathological physiology. Dr. Held brought out the fact that today the physician, as well as the surgeon, considered gall-bladder disease a surgical problem; but a problem that should not be attacked with surgery until thorough and adequate preoperative therapy was administered.

Following this paper, Dr. Victor Knapp and Dr. Louis Albright presented cases of atypical gall-bladder disease; and after the case presentations, the paper was discussed by Doctors Altschul, Rullman, Leonard, Pons, and Wiener.

HOSPITAL CONFERENCES

The following program was presented at the clinical conference of the Monmouth Memorial Hospital on Monday evening, January 14, 1935:

1. Treatment of Peripheral Vascular Disease
   Dr. O. R. Holters
2. Diabetic Coma with C O_2 of 11, Dr. Louis Albright
3. Diaphragmatic Hernia, Dr. Louis Albright
4. Leptothrix Pneumonitis, Dr. Frank Altschul
5. Atrophic Arthritis in a Child,
   Dr. Stanley Nichols
6. Osteomyelitis of the Os Calcis
   Dr. James Pregnall

The following program was presented at the clinical conference of the Fitkin Memorial Hospital on Sunday, January 13, 1935:

1. Anemia, Drs. Beveridge, Pons and Albright
2. Retraction Dystocia, Dr. Robert A. MacKenzie
3. Popliteal Abscess, Dr. O. K. Parry

PERSONAL NOTE

Dr. Robert E. Watkins, Belmar, New Jersey, Past President of Monmouth County Medical Society, was admitted to Fitkin Memorial Hospital, Neptune, New Jersey, on February 1, 1935, with tuberculosis of the seventh dorsal vertebrae. Dr. Watkins is now being prepared for an Albee Bone Graft. Arrangements have been made for Dr. Howard C. Pieper of West Long Branch, New Jersey, to take charge of Dr. Watkins' practice while he is ill.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

Responding to an invitation transmitted by Secretary Ward of the Morris County Medical Society, in behalf of Morris County Superintendent of Schools, Walter B. Davis, about 20 members assembled at the Court House in Morristown, the evening of January 30, to hear an address by Dr. Allen G. Ireland of the State Department of Education and Supervisor of Physical and Health Education of the State of New Jersey on the subject of "The Physician's Part in the School Health Program." Union County was also represented by Dr. Burritt of Summit, and Dr. Hallock of Berkeley Heights, and with others present the group aggregated about 30.

Opening the meeting Superintendent Davis expressed his pleasure in the response of the physicians and the speaker Dr. Ireland expressed his gratification of the attendance.

Dr. Ireland gave an inspirational discourse covering fully the aims and purposes and the underlying principles of child health and hygiene for the ultimate success of all educational efforts and the value of the physician's talents and knowledge in charting the course for better succeeding generations of which the school children of the present are the potential founders. This calls for get-togetherness, mutual responsibility and coöperation.

The purpose of the "Public Health Hour" is to stem the tide that was running away from the family physician and the physician's office. This is being tried as the best experiment that it was thought could be undertaken, and it will be carried on either to success or failure.

It is not the aim, or desire that the school assert any of the prerogatives of the home, nor is the school health program to be pointed to as a step toward State medicine, for this is not the purpose of the educational administrators of the State Department. Citing the various ways the program is worked in different counties, Dr. Ireland left the impression that it is for the individual county to work out its own problem and devise means of response to the "Public Health Hour" and to reach the children through the parents or the various school associations and other coöperative agencies.

Healthful discussion was aroused on the importance of a census of pre-school age children particularly from the standpoint of diphtheria immunization in the earlier ages.

Plans of coöperation were discussed, and altogether the meeting very apparently was well worth while from its various angles and standpoints.

Another of the series of "Clinical Club" meetings of the *Morris County Medical Society* was held at Morristown Memorial Hospital the evening of Thursday, February 21, 1935. President McMahon called the meeting to order with about 35 present.

Like its forerunners in this series put on by the staffs of the hospitals, State and General, within the County, it was of intimate interest and focussed attention on the special subjects presented, as follows:

1. "Some interesting Neoplastic Lesions of the Skin" by Dr. A. F. Galasso, Morristown, illuminated by a series of slide illustrations. Discussion was opened by Dr. Bart M. James, Newark, who gave freely and informatively of his store of knowledge of the subject.

2. "Coronary Occlusion" by Dr. R. L. Gilbertson, Madison, with slide illustrations by Dr. Galasso, the discussion was ably opened by Dr. G. J. Young, Morristown.

The subjects were presented and discussed in a very interesting way, both from the pathological and therapeutic standpoints, and following the opening discussions, discourse was taken up quite generally and various questions asked were adequately answered.

Buffet refreshments were served and a social period enjoyed.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Ritz Ball Room, Passaic, in conjunction with the meeting of the Passaic Practitioners Club, Thursday, February 14, 1935, at 9 p. m. Dr. Sobel, president of the Passaic Practitioners Club, welcomed the members of the Passaic County Medical Society, and then turned the meeting over to Dr. MacMillan.

Dr. Ira S. Wile, Associate attending physician of Mt. Sinai Hospital, New York, gave a very interesting paper on "Child Guidance as a Medical Function". In his paper, Dr. Wile made a plea to the general practitioner and especially the pediatrician to interest himself in this field in which the laity was even more interested than most physicians. The paper was a thorough and excellent exposition of the principles underlying the child guidance problem.

The following took part in the discussion: Dr. Ford, Dr. Levinson, Dr. Rinzler, Dr. Waasing, Dr. Joachim, and others.

Dr. Allen then presented a summary of an interesting case of cryptorchidism, complicated by diabetes insipidus. This case was treated with antuitrin S, with excellent results. The diabetes was cleared up and both testicles descended into the scrotum.

A report was then given by Dr. Norman Dingman on the conference held on Maternal Mortality.

The meeting was then adjourned, and the members gathered about the tables for refreshments and a social hour.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

About a hundred members gathered at St. Elizabeth Hospital, Elizabeth, N. J,, on the evening of February 13, for the regular bi-monthly meeting of the *Union County Medical Society,* with the president, Dr. E. S. Kraus presiding.

There were eight proposals for membership, to be acted on at the next meeting. The following Doctors were elected to membership: J. M. Carlisle, Rahway; G. W. Estey, Westfield; N. L. Russo, Union; and L. M. Townsend, Roselle.

The Society unanimously endorsed the candidacy of Dr. Charles H. Schlichter of Elizabeth for the position of second vice-president of the State Society.

Immunizations

In addition to routine business, the Society decided to pay for and distribute one hundred thousand letters throughout the county to the parents of school children, explaining the advantages and benefits of diphtheria immunization, and urging that all children be thus protected.

Scientific Program

An illustrated address on "Cancer of the Colon" was given by the guest speaker, E. J. Donovan, M.D., Attending Surgeon Babies Hospital, and Associate Attending Surgeon St. Lukes Hospital, New York. He interestingly discussed a series of 200 cancer patients upon whom he had operated.

After the meeting adjourned, refreshments were served and a social hour enjoyed.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The winter meeting of the *Warren County Medical Society* was held in the Elk's Club, Phillipsburg, N. J., January 22, 1935, at ten-thirty a. m. The meeting was called to order by the president, Dr. Herman Baldauf, of Belvidere.

The members and guests present were: Drs. F. A. Shimer, L. H. Bloom, E. Krausz, T. F. Spillane of Phillipsburg, Drs. W. H. Varney, W. F. Skinner of Washington, Drs. D. P. D. Jackson, H. Baldauf, G. W. Cummings of Belvidere, J. M. Smith of Hackettstown, F. W. Curtis of Stewartsville, H. B. Bossard of Harmony. Guests were Drs. R. M. L. Buchanan of Warren Hospital, J. M. Lemmon, Washington, William McMurtrie, Hackettstown, Homer Bloom, Easton, and Martin Kleckner, Allentown, Pa.

Dr. Martin Kleckner of Allentown was the speaker. He gave a very interesting talk on rectal diseases which was discussed by several members present.

Dr. William McMurtrie of Hackettstown was elected a member of this society, being transferred from Morris County. Dr. C. F. Smith of Oxford was also elected a member.

The application of Dr. J. M. Lemmon of Washington was received and laid over until the next meeting.

Drs. F. A. Shimer, L. H. Bloom and William Varney were appointed a committee on standardization of hospitals.

Drs. G. W. Cummings, H. B. Bossard and W. F. Skinner were appointed a committee to draw up resolutions of respect on the death of Dr. G. O. Tunison.

Dr. F. W. Curtis was elected a member of the nominating committee of the State Medical Society.

Dinner was served in the Elk's Dining Room after which the meeting adjourned.

THE WOMAN'S AUXILIARY

Atlantic County

Reported by Mrs. Violet S. Mason

A meeting of the Executive Board of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at 2 p. m. on Wednesday, January 30, 1935, at the home of the President, Mrs. James North. The entire meeting was taken up with discussion of plans for a Reciprocity Meeting and Tea to be held in colloboration with the Women's Club.

The February meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held at the Claridge Hotel, Atlantic City, on Friday, February 11, 1935, at 8.30 p. m. Mrs. James North presided.

Following the regular business, the reports of the various committees were given. Mrs. David B. Allman, Chairman of Entertainment, announced that a Reciprocity Tea would be held on Tuesday, February 19, in the Women's Club Rooms. Music will be furnished by Mrs. Laura Jackson, soprano, accompanied by Mrs. Raymond Williams, an Auxiliary member. The speaker will be Dr. D. Ward Scanlan, a member of the County Medical Society, who will talk on "Cosmetics, Drugs, and the Gullible Public".

The Corresponding Secretary was asked to send cards to members who are ill.

Mrs. Samuel Salasin, General Chairman for the Woman's Auxiliary to the American Medical Association in June, outlined plans for the convention, and appointed several committees.

It was proposed that Mr. Walter Gill, prominent Atlantic City attorney, be asked to give a talk on "Women in Law" at the March meeting.

Following adjournment, cards were enjoyed by the members.

Camden County

Mildred B. West, Publicity Chairman

The *Woman's Auxiliary to the Camden County Medical Society* gave a Musicale and Tea at the home of Mrs. Joseph E. Roberts, in Haddonfield, on January 22, 1935. It was one of the most enjoyable and successful affairs the auxiliary has ever given. There was an admission charge of fifty cents and not only a large representation of members were there but many guests as well.

The musical program was presented by a trio consisting of Morris Brown violinist, Joseph Vetere, violincellist, and Clarence Fuhrman, pianist.

Mrs. A. J. Casselman and Mrs. O. W. Saunders poured at the tea which was served after the musicale. Mrs. E. G. Hummel and her hospitality committee served.

The annual Public Relations meeting of the Woman's Auxiliary to the Camden County Medical Society was held in the Junior Ballroom of the Hotel Walt Whitman on February 5, 1935. Members of the auxiliaries of the adjoining counties, Parent-Teacher Associations and Woman's Clubs throughout the county were invited. Mrs. A. J. Casselman, chairman of the Public Relations Committee, presided at the meeting.

Dr. Leonard Rowntree, director of the Research Institute of the University of Pennsylvania and formerly of the Mayo Clinic gave a delightful talk on the "History of Medicine". The stereopticon views which were shown added greatly to the interest of the lecture.

Several vocal selections were rendered by Mrs. A. Lincoln Sherk.

Mrs. E. C. Rechin, president of the auxiliary, and Mrs. E. G. Hummel were hostesses for the meeting.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday afternoon, February 4, 1935, at the Y. W. C. A., the president, Mrs. Frank P. Nicholson, presiding.

The minutes of the previous meeting were read and approved.

The treasurer and the corresponding secretary made their regular reports.

The chairman of entertainment reported that a theatre party was not advisable, at present, and it was moved, seconded and carried that we have a card party. Mrs. Edward G. Waters of Gifford Avenue, offered her home, and the affair is to be held as a dessert bridge, on Wednesday, February 20, 1935, at one o'clock.

The Speaker's Bureau is functioning in twelve out of the fourteen auxiliaries, she said; and she also told that the State Society thinks very favorably of establishing a home for ill, aged and indigent doctors.

The speaker for the afternoon was Dr. Charles K. Good, of New York City, a skin specialist, who gave a most interesting and instructive talk, on the care of the skin.

Everybody is born with a good skin, the doctor said, and as the years pass it is but right that every one should aid in keeping it in that condition.

Time was when a woman put powder on her face or used a bit of rouge, she was whispered about, but nowabays nobody whispers about anybody, except perhaps to say that young girls use too much and the middleaged woman not enough.

Dr. Good advocated the use of good creams and powders, but begged above all, that his audience not buy just any kind of facial beautifiers because they happened to be done up in a dainty or attractive box.

Be sure that it is the kind of first aid that your own particular skin needs. Also he asked his hearers not to try something just because it seemed to work miracles with some one else.

It might be just the kind of thing that another skin could not tolerate at all. He added that the

time had passed when the market offered only two kinds of powder, one ghastly white and the other rosy pink; the first to make one look like a clown and the other as if a pink plaster had been applied.

Dr. Good also gave much practical advice on the care of the skin, and demonstrated, with the use of a chart, how to apply powder, rouge and lipstick; insisting that every woman owes it to herself to take time to make herself attractive, even if she has to neglect the family, once in a while, as it will be more than repaid by the pride her children will take in a well-groomed mother.

After the lecture, some time was spent in asking questions, and a social hour followed, when as chairman of hostesses, Mrs. A. C. Ruoff and her committee served refreshments.

Mercer County

An all-day meeting of the *Women's Auxiliary to the Mercer County Medical Society* was held February 11 at Mercer Hospital. Luncheon was served at 1 o'clock. The morning was devoted to making surgical dressings.

Among those present were: Mrs. Charles F. Adams, Mrs. A. W. Atkinson, Mrs. Arthur W. Belting, Mrs. Edmund W. Burroughs, Mrs. C. Chester Chianese, Mrs. H. Donald Cowlbeck, Mrs. Irwin P. Davenport, Mrs. J. Otis Denelsbeck, Miss Anita D'Gianni, Mrs. Alton S. Fell, Mrs. Leonard L. Friedman, Mrs. B. M. Goldberg, Mrs. Angelo D. Guglielmelli, Mrs. Edward K. Hawke, Mrs. Floyd D. Hunter, Mrs. A. Dunbar Hutchinson, Mrs. William C. Ivins, Mrs. J. F. McCullough, Mrs. James J. Ely, Stillwell, Renner, Flint, Hegeman, Meigh, Mrs. Francis E. Proctor, Mrs. Alvin S. Rogers, Mrs. L. Samuel Sica, Mrs. John B. Sill, Mrs. Clarence J. Slack, Mrs. Robert B. Stone, Mrs. Charles H. Waters, Mrs. B. R. Wayman, Mrs. D. M. Yazujian and Mrs. Joshua N. Zimskind.

Mrs. Alton S. Fell presided at the business meeting of the organization in the afternoon.

Passaic County

Reported by Mrs. B. W. Botbyl

The regular January meeting of the *Women's Auxiliary to the Passaic County Medical Society* was in the form of a luncheon and bridge held at the Alexander Hamilton Hotel, Paterson. Mrs. Burt W. Botbyl, president, presided. Spring flowers furnished the table decorations. Mrs. Louis Bohl, holder of lucky number 13 was the recipient of the special door prize. Arrangements were made by the Social Committee, Mrs. L. R. Taber, chairman, assisted by the Program Chairman, Mrs. F. W. Ash. Approximately forty members were present.

Somerset County

Reported by Mrs. Charles F. Halstead

The regular meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held at the Nurses' Home, Somerset Hospital, Thursday, February 14, at 8.30 p. m. Mrs. Lancelot Ely, presided. Eight members were present: Mesdames Ely, stillwell, Renner, Flint, Hegeman, Meigh, Baker and Halstead.

Minutes of the previous meeting also the treasurer's report were read and approved.

Eighteen dollars were realized from our card party held at the home of Mrs. R. F. Hegeman, January 24, 1935. Mrs. Edgar T. Flint was chairman.

Mrs. Meigh, chairman of Public Health and Public Relations Committee reported that Mrs. Renner and Miss Redfern had talked before Bernardsville audiences.

Mrs. A. L. Stillwell was appointed to write a history of our organization.

The auxiliary voted to contribute ten dollars to the Meeting Fund of the State Convention, also to contribute five cents per member to the Training School for Feebleminded at Vineland, N. J.

Delegates to the State Convention are: Mrs. L. Ely, Mrs. D. S. Renner, Mrs. Josiah Meigh; Alternates: Mrs. A. L. Stillwell, Mrs. B. S. Baker, Mrs. R. F. Hegeman.

Mrs. A. L. Stillwell gave a description of her recent visit to Labrador, after which refreshments were served.

Union County

Reported by Mrs. Frederick A. Kinch

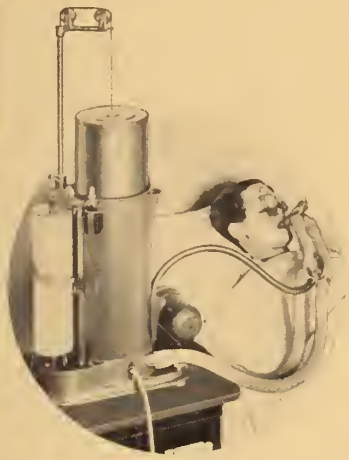
The February meeting of the *Women's Auxiliary of the Union County Medical Society* was held at the home of Dr. and Mrs. Charles H. Schlichter, in Elizabeth, Wednesday evening, February 13.

The message from the State President, Mrs. Arthur J. Casselman of Camden, was received with much interest. The society voted to double the usual contribution to the State Society, a part to be used for the State Convention to be held April 30, May 1 and 2, at Atlantic City, and the other half for the American Medical Association for its meeting June 10 to 14 in the same city.

Mrs. Russell A. Shirrefs of Elizabeth gave a delightful talk on "Perfume in the Garden", bringing out interesting facts in the relation of odor and fragrance to drugs and medicines. Her talk was beautifully illustrated by her own water colors of flowers, insects and other nature subjects.

A Dessert Bridge party is to be held at the home of Mrs. Harry V. Hubbard in Plainfield, on Friday the twenty-ninth of March.

A social hour followed the business meeting, during which light refreshments were served, Mrs. H. D. Corbusier of Plainfield pouring the coffee.



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ANNUAL REPORTS AND PROGRAMS
ANNUAL MEETING—APRIL 30, MAY 1 and 2
Haddon Hall, Atlantic City

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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Volume XXXII.
Number 4

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Under the
Direction of the
Committee on Publication

Editor of
The Journal
Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

Vol. XXXII, No. 4 April, 1935 Subscription, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

Expectations and Accomplishments

The Annual Meeting of *The Medical Society of New Jersey* affords the opportunity to balance its budget of expectations against its record of accomplishments. President Ely, in his report, refers to the action of the State Society in carrying out the plans of previous administrations, and establishing a consistency of policy and a continuity of action. He describes the progress in twenty-seven activities, and makes fourteen recommendations for the continuation and extension of the work during the coming year. The budget of *accomplishments* more than equals that of *expectations*, and leaves a large balance to be applied to working capital of the Society.

One of the greatest assets of a medical society is its "good will", or reputation for adaptability to the practical needs of both the doctors and the people. The State Society, with the coöperation of the County Societies, has promoted the interests of the physicians not only *financially* by the E. R. A. and the Lien Law, but also *socially* by the broadened contacts with lay health organizations, and its promotion of public health measures. What the medical profession is doing is of constantly increasing interest to the people as they comprehend the scope of the civic projects of the doctors.

A growing concept is that the *Medical Society* is the medical advisor of the people collectively—the *community*, just as the family doctor is the advisor of the sick individual. The people are beginning to recognize the *Medical Society* as the source of authority in all health affairs of a civic nature.

The medical profession is no longer a purely scientific group, holding itself aloof from the ordinary affairs of life and functioning only in disasters and unusual conditions. The Medical Society is coming to be recognized as an active participant in the civic affairs of a community, coördinate with the chamber of commerce, the school, and the church. This is a real accomplishment, achieved after years of wistful expectation.

Whatever brings honor and influence to the Medical Society is of benefit to the individual physician. The accomplishments of The Medical Society of New Jersey listed in the annual reports enhance the reputation of every member of the organization.

Publicity by Physicians

Great movements for the participation of the public in the delivery of medical services are fostered by two groups:

1. Lay health organizations.
2. Medical societies.

The people get most of their knowledge of public health projects from endowed "Foundations" which hire lecturers and publicity writers to instruct interested groups and to issue news stories of their activities. It is only in recent years that physicians have changed their code of ethics so far as to permit medical societies to compete with lay health organizations by presenting the views of the medical profession regarding the plans and aspirations of physicans who are actually engaged in the private practice of medicine.

Three major methods of publicity are available to physicians:

1. Public speaking.
2. Newspaper articles.
3. Radio broadcasts.

An address by a representative of the county medical society to a local audience is the most effective form of health publicity, because it utilizes the element of personal contact, in contrast with the impersonal mass methods of the foundations in giving out health information. Physicians have no funds for hiring speakers and writers; but they can adopt the more potent method of *volunteer speakers* appointed from among their own number by their medical societies. What the local doctors say has a far greater weight than the reported addresses of famous experts at a distant convention.

Objectives in Medical Publicity

The usual form of popular medical publicity has been that of instructing the people in regard to the nature of the thousands of conditions to which any person is liable. One of the most popular departments of every daily paper is the "Health Column", in which diseases are described and the futility of popular "treatments" are set forth with sarcasm. The impossibility of effective education of the people along these lines is evident when one considers the years which a doctor must devote to an intensive study of diseases in order to qualify for a license to *begin* to practice medicine.

Physicians object to health columns because they usually represent the opinions of *individual* physicians rather than those of the medical profession. There is also the suggestion of *self-advertising* on the part of the physicians who write the articles. This objection is partly met by the requirement that the column should be prepared by a physician authorized to write in the name of his medical society. This is a great advance, but there still remains the impossibility of educating any considerable group regarding the numberless conditions of ill health to which they are liable. Still the method is valuable in the presence of epidemics, which happily occur only at rare intervals.

A further advance in popular medical education was that of attacking the cultists and healers, under the belief that the skill of physicians would stand out prominently in contrast with the incompetence of the cultist. There were two great objections to this method:

1. It was passive in that it demonstrated the *absence* of scientific knowledge on the part of an inferior group, rather than the *presence* of outstanding ability of the medical profession.

2. It opened the door to charges—unfounded though they were—that physicians were jealous of the cultists.

Exposing the practices of the cultists has its place under certain conditions, as in combating legislative bills for the recognition of the incompetent healers; but under ordinary conditions it fails to promote respect for the medical profession.

The most needed form of medical publicity is that educating the people regarding the place of the County Medical Society as the medical advisor of the community. Announcements by the medical societies of their readiness to give medical advice in civic projects will result in their being invited to assume the leadership in public health projects.

How to Read Your Journal

Ask a doctor how he reads his State Journal and he will be likely to say that he skims through it when he receives it and notes some articles which he expects to read carefully when he gets the time.

There always comes a day when the doctor wishes the information contained in some article which he had not noticed at all; and by that time he is probably unable to find the particular number that he wants.

The Journal of The Medical Society of New Jersey had a triple value—as a news pamphlet, as an educational text-book in science and economics, and as a volume of records of the activities of the medical societies.

It is as a volume of reference that The Journal is of the greatest permanent value.

When a doctor wishes an item of information, or the name of a committeeman, he usually wants to use it *at once*. This is the most compelling reason for placing every copy of your Journal in a certain place as soon as you receive it.

The Journal box supplied to you through the State Society to be kept in plain sight on your desk is a constant invitation for your attention. And when you are searching for an item of medical society action, the volume standing on your desk will dance before your eyes, compelling your recognition. If you place every Journal in the box, you will read the news items when you receive your copy; you will study its educational articles at your leisure; and you will use it as a reference volume in times of need and emergency.

Follow-up of a Resolution

It is an American trait to buy immunity of one's conscience by passing a law assigning an evident duty to some one else against his will; and then the proposer of the law refuses to go to court and give evidence that would convict offenders. The proposer eases his conscience with the plea that he is not an officer or detective; but he would like to impose that unpleasant duty on some one else. He is willing to let George, or anyone else, do it, if only he doesn't have to.

It is easy for a County Medical Society to pass a resolution regarding a line of action; but try and get the members to carry it out! The Medical Society of New Jersey is efficient because it always creates the machinery to carry out a project, and then sees that it operates. But as a matter of fact, the county societies also are rapidly improving in carrying out the resolutions which they pass.

Continuity of action is largely a matter of habit, developed first by a few leaders in a few societies, and spreading by contact until it inoculates the whole group. One of the first-fruits of the establishment of the Executive Offices is the inspiration arising from the constant contact that is maintained with the promoters of State Society projects in every County Society.

The facilities of the Executives Offices are at the service of any County Society that needs advice or assistance.

Contacts With Lay Health Organizations

It is the policy of The Medical Society of New Jersey to make contacts with other community agencies, in order to discuss the health implications in their programs.

These contacts are established through the staff and members of the State Medical Society, or someone assigned to a single group or meeting.

A list of such organizations contacted and the name of the approved medical representative, together with the subject of any address or discussion in which he took part, should be reported to the Executive Secretary of the State Medical Society by the person officially attending such a meeting.

The purpose of these reports is two-fold:

1. That this information may be carried in The Journal.

2. That the reports may be placed on file in the Executive Offices, and included in periodic reports on the activities of the Society.

This will provide a basis of understanding between the lay health organizations and the physicians; and will promote coöperation between the medical profession and the lay agencies.

The number of such contacts is already larger than is generally realized, and their extension is a valuable opportunity for increasing the influence of physicians on the civic life of every community.

Horizons of Vision

Dr. Oliver Wendell Holmes describes one-story and two-story and three-story men according to the height and depth of their mental outlook and to the extent of their fields of vision and interest. Physicians fall naturally into these classifications.

The one-story doctor deals with the small round of *"immediate facts"* with which he is confronted—this patient dissatisfied, that bill unpaid, and that afternoon golf game postponed. These small matters concern few persons besides himself, and he is not particularly concerned with the affairs of any other doctor and with those of any other patient than his own. He values his medical society for the dividends which it returns to him upon his invested dues.

But let no one underrate the one-story doctor. His very concentration of effort may be a source of strength in some one line; but he may know so much about one thing that he is deficient in other lines. Great specialists are sometimes that way—absentminded on common subjects which are of absorbing interest to their colleagues and neighbors.

Every one-story doctor is of essential value to a county society as a faithful private or a non-commissioned officer. No one can foresee the extent of his interests or of his contacts with laymen, especially with those legislators who are his friends. The very restriction of his field of view may make his insight the more acute in the details of his own local field. Here is a place for every doctor in a county medical society.

The two-story doctor looks into space and time twice as far as his one-story colleague and covers four times his area of vision. He is concerned not merely with facts, but with the *"laws"* of their occurrence and their different interpretations by his colleagues of various temperaments. He is a wise man in his medical society, and his advice is sound and is usually heeded. He sees recent facts in their true perspective, and deals with the future developments of present events. He is a good judge of men and their motives and an excellent prophet of their actions. He is a capable field officer and may rise to high ranks in the medical society of his county, state, or nation.

The three-story doctor deals with *"universal truths"* derived from *laws* and *facts*. He considers medical service in relation to other fundamental needs—physical, mental, moral, and spiritual. He brings the services of the state, the school, and the church to the assistance of medicine; and on the other hand, he correlates the services of medicine to those of education, engineering, law, sociology, and religion.

There are third-story men who live exclusively in their own cloudy castles and yet assume to devise systems of medical practice for physicians and patients on the ground floor of a life which they never experience. The service of medicine today requires the leadership of doctors of wide outlook who occupy all three stories of the House of Medicine, and are as much at home with a maternity case in a crowded tenement as on a platform of a conference on social security.

THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS

of the

OFFICERS AND COMMITTEES

TO THE HOUSE OF DELEGATES

April 30, May 1 & 2, 1935

THE ANNUAL REPORT OF THE PRESIDENT

Lancelot Ely, M.D., Somerville, N. J.

To the House of Delegates:

The work of your President requires much time and effort but it has its rewards as well as its obligations. It has been a privilege and pleasure to meet so many willing and able workers on the various committees which shape the plans of the State Society. It has been equally enjoyable to get closer in touch with the individual members of the County Societies where new leaders are constantly being discovered whose talents must eventually be recognized and used in the State Society to greater advantage in the interest of our profession.

Your President realized long ago that the program laid out by his predecessor, himself and his successor involved continuity and was too large to be completed in any one administration. Upon assuming the highest office in the gift of his professional colleagues in New Jersey, he decided to devote his talents and energies to the consolidation of the advances already made and to finish a part of the remaining tasks.

To this end he has taken up a few problems at a time and endeavored with the aid of the various committee members to see these selected projects through to completion. In this he feels that he has been reasonably successful, and those which still remain unfinished re turns over to his successor with mingled relief and regret, to step back into the ranks and "carry on" with the rest of the members in our united efforts.

It is becoming apparent to all of us, I believe, that the future medical practice will in the last analysis depend not only upon our individual effort, but more upon the *organized effort* of every single member in every County Medical Society who must learn to do his full part as a member of our *organization*, and as a true disciple of Aesculapius, working in the interests of our profession and of the public we serve.

Among the accomplishments of the past year might be listed:

1. The passage of a new Physicians' Lien Law. This bill removes the objections of the Bar Association and the Insurance Carriers and is much more practical than the fee schedule bill of last year. This bill is now Chapter 146, Laws of 1935.

2. In passing the bill which preserves the dedicated funds to the Professional Boards, able assistance was given by our Keymen. This bill is now law, Chapter 121, Laws of 1935.

3. Success so far in combating the strong pressure on the Legislature for undesirable cult bills, i. e., Osteopathic Bill and the bills to govern chiropodists and hairdressers.

4. The preparation of a Uniform Medical Practice Act for introduction next year in the Legislature. Members of the State Board of Medical Examiners were added to the original committee because of their valuable experience.

In the Public Health Committee of the Assembly now rests A-238, the bill intended by its sponsors to expand the present limitations of the Osteopathic Act without increased requirements for those who now practice under limited licenses.

Your President has informed the members of the Public Health Committee in the Assembly that The Medical Society of New Jersey now has a new Medical Practice Bill for introduction next year into the Legislature. This bill was drawn to provide for unrestricted practice of "the healing art" *by all who can meet the requirements therein stated.* This bill will also provide opportunity for those now licensed under restrictions to continue as before. For all who show satisfactory evidence that they are adequately *trained in academic and professional subjects* in conformity with the standards set, and who wish to specialize in or to use the technics of *any* of the legally approved methods of treatment, permission is given.

5. All of the bills involving Medical Practice proposed for introduction into State and Federal Legislatures which we have been able to obtain have been analyzed and studied by our Executive Secretary and the Chairmen of our Legislative and Medical Practice Committees; and our official representatives have been notified as to the attitude of the State Medical Society on these bills.

The President or Committee Chairmen appointed by him have attended meetings in this State, in New York, in Philadelphia, in Atlantic City, and in Chicago where the several state representatives have discussed threatened legislation unfavorable to the medical profession and have made specific recommendation to the special meeting of the House of Delegates of the A. M. A. called to discuss Medical Economics.

6. Thirty representatives of our Society attended the Annual Conference of the New Jersey Social Workers where 2000 people were gathered last December; and their presence was noted and appreciated as an evidence of our interest in the viewpoint of others in the community. We should be aware from first-hand knowledge of the attitude and ideas of influential lay groups on subjects under discussion as they relate to proposed legislation and practice affecting our interest.

7. When National Legislation to insure "Social Security" was being strongly advocated in Washington your President wired and later wrote a letter to President Roosevelt, Secretary Perkins, Senators and Congressmen from New Jersey and the members of the Advisory Committee appointed by the President to develop and recommend to him measures to insure Social Security, stating our opposition to governmental control and administration of medical practice. The replies received showed that these protests were not without influence on these influential leaders.

The telegram and the subsequent letter read as follows:

"On November 14th, 1934, as President of The Medical Society of New Jersey, I sent the following telegram to the members of the Committee on Economic Security under the Honorable Frances Perkins, at their meeting in Washington:

> "'The policy of The Medical Society of New Jersey is that, in any medical program for the benefit of the indigent and those in the low income group, the planning and conducting of the work in each state should be in the hands of the medical agencies which were founded primarily for health service, such as the State Medical Society and the Department of Health. The Medical Society of New Jeresy is now operating practical projects conforming to this policy and to the ten principles enunciated by the American Medical Association. It is our opinion and we urge that these general policies should be carried out.'"

On December 29th the following letter citing the above telegram was sent:

"The President and the Board of Trustees of The Medical Society of New Jersey again protest against hurried legislation intended to establish compulsory medical service under government control and which is not approved by truly representative groups of the practitioners of medicine. The approval of organized medicine is needed to safe-guard the sound principles of medical practice which have been gradually evolved out of many years of intensive study and practical experience. Our experience with the Emergency Relief Administration Program has shown the complexity of the problem of medical relief and the need for a gradual normal development of such services under mutual agreements and approval.

"Respectfully submitted,
"Lancelot Ely, M.D., President."

8. The studies and recommendations of the various standing and special committees are to be found in the reports presented in the April Journal of this year, so comment need not be made at this time.

It is a pleasure to report the definite or tentative appointment of the following committees to the State Society during this year:

A Cancer Committee
A Tuberculosis Committee
A Mental Hygiene Committee
A Medical Bills Committee
A Committee on Nursing and Nursing Education
An Advisory Committee to the Woman's Auxiliary

9. Your President called a conference, early in January, of selected leaders of the State Society to consider medical economic plans for New Jersey. This problem was referred to Dr. Lewis' Committee on Medical Practice and this committee has presented a tentative basis for the development of a New Jersey Plan for Medical Practice in case a radical change becomes legally compulsory. This plan will be further developed during the coming year and now serves as a counter-plan to any proposed by governmental agencies.

10. Dr. Mount's Committee on The New Jersey Medical History Publication has been

increased to include most of the original subscribers to this project and the work of preparing the data for publication is being advanced.

11. A Medical Bills Committee has been approved for each Judicial Councilor District with headquarters in Jersey City, Newark, Trenton, Camden and Atlantic City. This Bills Committee is an arbitration committee on disputed bills. Dr. David A. Kraker is Chairman of the State Medical Bills Committee and represents The Medical Society of New Jersey. Dr. Henry B. Kessler is Chairman of the representatives of the Rehabilitation Examiners; and Dr. Charles G. Crane is the Chairman of the representatives of the Industrial Surgeons. This committee will receive bills on which complaints have been made and will refer these bills for consideration and adjustment to the respective District Bills Committee in which the complaint originates.

12. The Workmen's Compensation Committee has had to await the proposals made to the legislature as a result of the recommendations of the Legislative Committee. These proposals embodied many of the suggestions made by our Committee to the Legislative Investigating Committee before whom they appeared last year. Several bills have appeared in the Legislature this year, dealing with the subject of Workmen's Compensation; and copies of these bills have been sent to the Chairman of the Sub-Committee on Workmen's Compensation.

13. The President has kept in close touch with all committees through personal attendance upon their meetings or through his representative—the Executive Secretary. This has made it possible for him to have detailed information almost immediately on the subjects discussed and the action taken by each Committee.

14. A Speakers' Bureau in the Woman's Auxiliary—which, while it needs further development and support, is functioning.

Under the Woman's Auxiliary is also now placed the annual "Arts and Hobby Exhibit" and other important duties at our Annual Convention.

15. Improved understanding and relations with other community organizations, both lay and official, who are interested in health problems.

16. Further study and experiment in furnishing *organized* medical service to indigent and low-income levels—chiefly in coöperation with the E. R. A. and the State Department of Health, through the two projects sponsored by The State Medical Society (i. e., "Public Health Hour" and "Medical Relief for Indigents"). These projects are in reality a part of the larger problems of experimentation in improving our medical service to all people in the State.

17. Conferences with officers of the New Jersey Hospital Association and Department of Institutions and Agencies have developed a tentative plan of approach to the proposed hospital survey and rating. This plan requires three preliminary steps:

a. A self-analysis questionnaire sent to those connected with hospital support, control and service.

b. Exchange of opinions and suggestions between three main groups of persons involved.

c. Formulation of standards; and the conduct of independent unbiased surveys of hospital construction, equipment, and operation.

Periodic surveys should be made of the hospitals in New Jersey and should be reported to The New Jersey Medical Society, for use in connection with past surveys and recommendations.

Hospital services as a special problem is an integral part of medical service in the community, and the medical profession must be kept informed of hospital developments through reports and surveys made available to them through their Medical Societies. The medical staff, trustee, and hospital administration relationships must inevitably be included in these studies at such time as mutual confidence and a desire to improve these relationships become evident.

18. *Advances in centralization of the clerical and administrative work* of the Society in the Executive Offices where there is now kept in a card index system a card for each member which gives all the essential data relative to his professional training and qualifications. We hope to add to this data gradually his special interest, and his special training and experience. These records will permit, with the aid of the County Society Secretaries, the "Official List" to be kept more accurate and up-to-date through monthly "check-ups" throughout the year. The entire membership can in this way be checked monthly with little effort.

19. *Radio broadcasting* by reputable physicians in organized societies is increasing. The Atlantic County Medical Society sets the pace in New Jersey. Among their speakers was your State President. It is difficult to gauge accurately the results of these efforts but since so much untruth and distorted health information is put out over the air by commercial

firms, it seems most desirable that the public be reminded that the medical profession is still the most reliable source of information related to health preservation and restoration. Wherever broadcasting facilities are available, the County Medical Societies should offer speakers, and place the scheduling and dispatch of such speakers in the hands of a small but efficient committee.

20. *Conference of Allied Medical Professions*—Headquarters in Executive Offices of The Medical Society of New Jersey.

The Conference of Allied Medical Professions has been definitely organized with a Constitution and By-Laws. Officers have been appointed and headquarters in the Executive Offices of The Medical Society in Trenton have been established. No entangling alliances have been entered into, but a mechanism has been provided by means of which common problems can be discussed by delegated representatives of each of the four groups concerned and united action recommended when unanimously approved. The Conference also provides a Clearing House for the discussion and solution of any difficulties which arise.

County Conferences were urged in each County and an organization has now been set up which can function quickly and effectively in the interest of the four allied medical professions which compose the Conference.

21. *Preschool Age Forms.*—School medical inspection in its present form is both wasteful and ineffective. The greater part of the defects discovreed in school should have been treated earlier in life and all of the preventive immunization and vaccination should have been completed long before the child reaches school age. Early training in health habits and in personal hygiene is a function of the parent guided by the family physician.

To further these ends the Public Health Committee has provided a practical preschool age supervision record which will eventually furnish to the school better physically qualified pupils and more reliable data on those children who have failed to prepare themselves physically before entering school. This data will also guide the parent and school teacher in making adjustments in the daily routine of the child in the home and in the school, to accommodate non-remediable or neglected handicaps which the child might have. Here is an enormous field for the interested physician with initiative and a real desire to be of service. Unless the private physician shows greater initiative and increased interest in this preschool age group, other organized community agencies will continue to wean away from him children whose parents would gladly pay for helpful service given by a competent doctor of their own choice.

These forms are available *at cost* at the Executive Offices in Trenton, and also through the Secretaries of the Component County Medical Societies.

22. *Birth Certificate Record Forms.*—A very attractive birth certificate form, with most pertinent immunization data, has been furnished by one of the high-grade commercial organizations, without charge and without any advertising. These birth certificates have upon them the seal of The Medical Society of New Jersey and may be obtained without charge through the County Medical Society Secretary.

23. *Public Health Hour Promotion.*—In the Public Health Hour the success now depends chiefly upon the initiative of the private physician in urging upon his own patients, by means of prepared letters and cards or personal letters, the protection of children against diphtheria and smallpox, preferably before the end of the first year of life and certainly before the end of the second year. Greater interest and coöperation on the part of the majority of physicians is necessary if this plan is to succeed. During the past year the number of preschool age children immunized has been increased somewhat, but the *total* number of immunizations in the State has fallen off greatly; and we as physicians are now faced with the alternative of providing approved clinics in certain areas for those who can not pay and will not go to the doctor's office for such service or leaving this function to Health Department officials with our approval.

24. *Conference with Governor Hoffman.*—A conference with the new Governor shortly after his inauguration was held by your President, the Executive Secretary, Dr. Fithian, and Dr. Snedecor regarding E. R. A. Medical Relief Problems and the new E. R. A. set-up.

The results of this conference were most satisfactory and the Governor has since appointed two of our most active members to important State positions—Dr. Spencer T. Snedecor on the State E. R. A. Administrative Council and Dr. Stanley Nichols on the State Board of Health.

25. *State Society Exhibit.*—An exhibit is being prepared for the Annual Meeting of The Medical Society of New Jersey in May and for the American Medical Association Convention in June.

This exhibit will show the organization, relationships, and procedures of the State and County Medical Societies; and the way in which special service projects are handled.

Graphs, records and literature will be included to explain the work.

26. A special lot of paper has been purchased in which the seal of The Medical Society of New Jersey has been water-marked during its manufacture. By purchasing in large lots the price is approximately the same as heretofore and a better grade of paper is obtained.

Component Societies can purchase this water-marked paper and have their County Society heading and officers printed on it. Perhaps eventually each member might become better identified as a physician in good professional standing by the use of this water-marked paper. The last is of course just a suggestion.

27. Your President has visited all the Component Societies which extended special invitations to him, and he has been impressed with the increased interest and unity shown at these meetings. Organized effort in the County Society has proven its value to the members in those counties where the E. R. A. program has been carried on regularly and in the right spirit by both sides.

RECOMMENDATIONS

In my Inaugural Address last year I made the following suggestions:

1. Develop Public Health activities which redirect the patient to the office of the private physician.

2. Further coöperation between the physician, the patient, and the Workmen's Compensation Board to curtail delay in payment and duplication of effort.

3. Continue to improve the E. R. A. cooperation plan.

4. Study and outline a Uniform Medical Practice Act.

5. Payment to the physician for hospital and dispensary services.

6. Establish a Speakers' Bureau in the Woman's Auxiliary.

7. Further mutual understanding and cooperation with other state agencies, especially the Department of Health, the Child Welfare Board, the Board of Medical Examiners and the Department of Institutions and Agencies.

Some real progress has been made toward these ends and I recommend continued effort toward these aims, and in addition to these recommendations I would also add the following:

1. Individual physicians serving in community activities should be approved by their Medical Society and be recognized by other groups as delegated representatives of organized medicine as represented in the County Medical Society of which they are members.

2. I would recommend provision in the Annual Budget of the State Medical Society of a sum sufficient to reimburse State Committee Chairmen for the expenses incurred in connection with their work and in attending Conferences and Meeting to which they contribute their valuable time so generously to the benefit of the Society and its members.

3. In consideration of the great amount of work related to hospitals within the State and with the ever-increasing activities in connection with post-graduate and medical education, I recommend that the Committee on Hospitals and Medical Education be divided into two separate committees, one to be known as the Committee on Hospitals and the other as the Committee on Post-Graduate and Medical Education.

4. All State Committees should see that minutes are taken of each meeting and a copy of these minutes forwarded to the Executive Secretary in Trenton for the information of the President and for filing for future reference.

5. The County Society should be the agency through which all medical activities are arranged. I recommend as soon as possible that there be a central office and a telephone number announced for the benefit of those interested persons and groups in the community who need help with their medical and health problems. Prompt action should be taken on such requests made for coöperation by the Medical Society members under satisfactory arrangements.

6. "Standing Orders" to govern visiting nurses should be uniform throughout the State. The "State Committee on Nursing and Nursing Education" has studied and proposed such orders which are to be used only in emergencies and until the physican arrives on the case.

7. I recommend better understanding and closer coöperation with the nursing groups who during my term have shown a desire to work in close coöperation with the medical profession. This support we must approve and reciprocate for our mutual benefit and the benefit of the patient.

8. Your President has attended meetings of the New Jersey Surgical Society and the Essex County Anatomical and Pathological Society during the year. It is his opinion that these societies, which are doing such excellent work in their specialized field, should in some way become affiliated with the State Medical Society so that more of our medical men in this State could receive the benefits of these scientific contributions.

9. I have asked the Chairman of the Pro-

gram and Arrangements Committee for the appointment of a Reception Committee to look after the interest of the speakers and invited guests at the State Convention, and also at the meeting of the American Medical Association.

10. I recommend the organization and use in each County of a County Conference of Allied Professions as component units under the State Conference of Allied Medical Professions, in order to make the recommendations of the State Conference effective for the benefit of the members of all four professions, and of the public whom they serve.

11. I recommend that every County Medical Society publish a monthly bulletin such as the majority of our component societies now provide. These bulletins are very valuable not only to the members in the County Medical Society, but to the State officers and committees, as well as the Executive Office staff, in acquainting them with coming events in the County Society. Whenevar possible advantage may be taken of the benefits provided by the County Societies in their scientific and social programs. I have noted an increase of interest and coöperation and also the fine support and teamwork developing in the counties, and I attribute some of this improvement to the monthly bulletins.

12. I recommend better organization within County Medical Societies to insure coöperation with the State Society and with community agencies who can help the profession in many ways if we respond to their reasonable formal requests to the physicians through the County Medical Society, as in the E. R. A. and Public Health Hour Projects.

13. I would recommend further experiments in the development of better distribution of medical services in each County so that the State plan now being worked out by Dr. Lewis' Committee may have the benefit of each County Society's experience and suggestions.

14. I further recommend that care be exercised by each individual physician to avoid enlisting his services in any new medical project until approved by his County Medical Society.

I wish to thank the Chairman of the Board of Trustees, Dr. Eagleton, for his excellent advice, his assistance, and his unfailing coöperation during my term of office; and each Committee Chairman for his loyal support; and to express my appreciation to each Committee member for his helpful coöperation.

The members of the Woman's Auxiliary have shown a commendable willingness to aid in their sphere of the work and their help has been very valuable.

In closing I wish to express my appreciation to Dr. Morrison, our Secretary, Dr. Overton, the Editor of The Journal, and Dr. Wilkes and the loyal staff at the Executive Office for their faithful and efficient service in the interests of the State Society.

Respectfully submitted,

LANCELOT ELY, M.D.,
President.

March 25, 1935.

THE ANNUAL REPORT OF THE EXECUTIVE SECRETARY

By LEROY A. WILKES, M.D., Trenton, N. J.

The work of the Executive Secretary and the staff in the executive offices in Trenton was outlined in detail in the report submitted last year (Journal, May 1934, p. 256). A detailed report of the activities and expenditures of the Executive Secretary and staff is sent monthly to the President and the Chairman of the Board of Trustees.

In the Annual Report for this year a progress report is offered to point out the important activities, and especially to stress those in which there is room for improvement and to suggest ways and means by which further progress can be made. Difficulties encountered are discussed, not to present an alibi, but to furnish facts which must be faced in planning for further improvements necessary to adapt medical practice to the changing conditions which now confront us.

THE OUTSTANDING NEED

The outstanding need at this time is better *organization* and coöperation within the County Medical Societies. Each member must become aware of the problems being studied by the State Society Committees, and become convinced that in the final analysis, the medical profession will succeed in exact proportion to the individual and coördinated effort which insures teamwork in the development of the projects sponsored by the State and County Societies. Each member is one of the units which go to make up the society of his county and his state; and in return for what he re-

ceives, he should be willing to sacrifice an occasional immediate personal advantage for the good of the profession as a whole. This is a new development and experience for so individualistic a profession as medicine has been in the past.

TEAMWORK ESSENTIAL

The outstanding weakness of the medical profession everywhere today is lack of organization and unity (outside of the hospitals). Great advances have been made in the State Society organization and teamwork in the past year, and in some county societies good work has been accomplished on certain assignments. The need for unity and plans which can be definitely scheduled and dispatched on time through a business-trained executive seems apparent. An executive employed by the County Society which has a headquarters, a telephone, and definite office hours is a regular part of the larger county societies. Such service in time pays for itself in benefits received by the members, and in actual cash collected by the Society. County Societies need such a spark-plug to insure function, and to supply to the members quick dissemination of state plans and information. Some of our County Societies demonstrate the truth of this assertion.

PROFESSIONAL PRACTICE

The scientific practice of medicine has kept apace of scientific discovery and this has been recognized by the public. With this progress has also come advancing cost to the patient, and lowered income to the physician. Professional progress cannot be sacrificed at any cost, but a better distribution of the burden of this increased cost must be accomplished through improved method of supplying the services of the profession to all the people, at a cost they can afford to pay.

This is possible through some method by which a large part of the costs of such professional service can be lifted from the shoulders of the doctor, who gives the service, and placed upon the community through taxation, or on groups of people through a proper adaptation of the insurance principle.

The Business of Distributing Services.—The solution of this problem entails a better understanding and use of *business* methods. Economy in time and effort in private physicians' offices through better plans and schedules offers some hope; and wider participation by practicing physicians in public health activities and in preventive practices, for which the physician is adequately paid, would increase medical practitioners' incomes and provide wider distribution of medical services to the lower income patients. These suggestions are made to stimulate thought and action.

CONTINUITY OF PROGRAMS

The activities of the State Medical Society, and therefore of your Executive Secretary, fall theoretically into two main categories:

1. *Unfinished Business* (from the preceding administration) which is completed or passed along for completion to the next administration.

2. *New Business*—Initiated under the present administration and either completed or passed along if need be to the next administration. This *obvious* fact is mentioned merely to emphasize the *continuity* of the program of the State Medical Society and the increasing endeavor on the part of the officers to plan far in advance of the current year so as to provide for consistency, cumulative achievement, economy, and efficiency.

We are discovering how often the same problems bob-up; and when a palliative treatment has been given, this has merely sufficed for the moment. Such methods are inadequate and ineffective; and until some one is able and willing to follow through until the best practical solution is reached, no real progress is made. This fact confuses the classification of what is new or old business.

IMPROVED ESPRIT DE CORPS

The increased *esprit de corps* in the State Society is most encouraging, and the increasing efficiency which has resulted is unmistakeably evident. Extension of this fine spirit into the county societies is most desirable, and is absolutely necessary if the medical profession is to maintain its own control and direction. *Time is valuable, and we dare not waste it in useless discussions before we make our unity of purpose and action apparent in every county.*

COMMITTEE REPORTS

The *reports of our standing and special committees* should be carefully studied by each member who wishes to keep abreast of the times and fit himself to meet the demands now made upon the members of the medical profession and to provide for the future.

The *Medical Advisory Committee to the State Emergency Relief Administration* has been burdened with the largest amount of work, and the most exacting decisions to support. The greatest amount of sacrifice on the part of the members, especially of the Executive Committee and the able Chairman, has been cheerfully made. Governor Hoffman has selected the Chairman (Dr. Snedecor) to be

a member of the State E. R. A. Administrative Council where his extensive experience will be most helpful in providing a sound medical viewpoint in relief problems.

The *Public Health Committee* probably comes in for second honors in hard work and continued efforts to serve the Medical Society interests through the Public Health Hour project. The Chairman, Dr. Nichols, has been appointed as a member of the State Department of Health where the interests of the medical profession will be safeguarded, and the public better protected.

The *Welfare Committee* has met its obligations well, and the smooth running of the Society program has presented for the consideration of its members comparatively few problems for solution.

The *Special Committee on Physician Lien Law* has been very active and efficient and has ironed out, with the aid of the Board of Trustees, the difficulties met in the Courts with the former law, and has had prepared the new bill which is now law. Dr. Weigel as Chairman of this Committee has been especially active and effective.

The *Sub-Committee on Legislation* has had a successful year. Only one medical bill was introduced by the State Medical Society. This was a new Physicians' Lien Law to replace the present Lien Law and remove the objections which caused the Bar Association to institute legal proceedings to prevent its operation. This bill is now Chapt. 146, Laws of 1935 of N. J. The bill A-28, which was passed recently and is now Chapt. 121, Laws of 1935 of N. J. restores to the Professional Boards the collection and dispensing of their collected funds. The Medical Society "key" men aided greatly in the passage of this bill. Other legislation coming before the Committee will be found in the report of this Committee.

The *Sub-Committee on Uniform Medical Practice Act* has now a bill which will be ready for introduction next year in the Legislature.

A *new Special Committee on Nursing and Nursing Education* was appointed this year by President Ely to study problems and relationships affecting nursing and medical practice and to promote harmony and efficiency through coöperative effort.

A *special Advisory Committee to the Woman's Auxiliary* was also appointed this year to aid in the work of the Speakers' Bureau, and in the further efforts of the Woman's Auxiliary.

The *Special Committee on Arts and Hobby Exhibits* is advisor to the Woman's Auxiliary which this year will have charge of the exhibit in the Devonshire Room at the Annual Meeting in Atlantic City.

These are the committees with which the Executive Secretary's contacts are most frequent. The individual committee reports in the April Journal will contain further details regarding the aims and activities of these committees.

THE COUNTY SOCIETY BULLETINS

The *County Society Bulletins* now generally in use are a great forward step. Every Society *can* afford to issue one, and should do so. They have a value far greater than to notify the members as to the next meeting. They are "reference material" too, and in the State Society Executive Offices in Trenton, we use them constantly:

1. To keep up to date our records of County Officers, Delegates and Committee Chairmen and Members.
2. To know *in advance* what is going on in the County Medical Society.
3. To note *special experiments* and activities in the society and *problems under discussion* at the time.
4. To get subjects for editorials in the Journal.
5. To find out about the "Good Times" being prepared in your County Society or District meetings which your President and his "chief of staff" might like to attend.
6. To learn of changes in time or place of regular and special meetings of the County Society.

The State Medical Society officers and staff are not able to be with you at your meetings as frequently as we would like; but we do know a good deal about you and what your component society is doing through the "Bulletin" issued by your society, and through the reports in the Journal which are sent in regularly by your Society's official "Reporter".

Contacts with Other Organizations in the State

The following agencies were contacted through mutual efforts this year:

1. State Department of Health (plus local Health Departments)
   a. Administrative Division
   b. Child Hygiene Division
   c. Public Education (Journal)
2. N. J. Dental Society
3. N. J. Pharmacists
4. Nursing Societies of New Jersey
   a. N. J. State Nurses Association
   b. Visiting Nurses Association of N. J.
   c. N. J. Organization for Public Health Nursing

5. E. R. A. (Family Service Division)
6. N. J. Tb. League (Publicity and Finance Promotion)
7. N. J. Conference of Social Work
8. P. T. A. (Public Health Hour)
9. Women's Federation Clubs (Public Health Hour)
10. League of Women Voters (Public Health Hour)
11. N. J. Health and Sanitary Association (Public Health Education, Survey and Promotion)
12. Woman's Auxiliary to the Medical Society (Speakers' Bureau and other projects)

The future should bring greater opportunities for coöperation in the work of industrial, school, and other agencies.

The *"Public Health Hour"* Project has been a vehicle for better organization, understanding and coöperation with the official health administration agency of the State.

CO-OPERATION

Mutual understanding and coördination of plans and efforts between the *State Health Department* and the State Medical Society are essential to the ultimate success of both these groups. The same may be said of the work of the members of the *Allied Medical Professions,* and a good start toward the latter has been made in the establishment of the organized "Conference".

The Medical Society should provide recognized avenues of approach and every opportunity by means of which those groups in the State and Community which are not *primarily* health agencies, but which are faced with essential *health* problems in their work, may define, and formally present, these problems to the State Medical Society for solution and aid.

ACTIVITIES IN THE EXECUTIVE OFFICES DURING 1934-35 IN COMPARISON WITH 1933-34

Average per Month	1933-34	1934-35
Letters received	142	120
Letters dispatched	942	953
Mimeo stencils cut	37	46
Mimeo pages	2282	3277
Meetings attended	11	11
Conferences attended	14	14

This year the Executive Secretary acts as Secretary to the Program and Arrangements Committee for the Annual Meeting. This brings additional duties to this office.

The Conference of Allied Medical Professions was formed this year. Dr. Haggerty accepted the appointment as Secretary, provided the clerical work involved would be done in the Executive Offices of The Medical Society.

Notices of meetings, agenda of meeting, and minutes of meetings are compiled and distributed from this office.

The Executive Offices accepted the loan of an addressograph from the Mercer County Medical Society with the proviso that this Society's notices would be addressed and sent from this office. Frequently the notices have to be mimeographed also.

An official card index system of each member in the State and County Medical Societies in New Jersey is now available in the Executive Offices in Trenton. This list will be checked monthly and kept up to date, and the "official list" can be readily printed each year without extra effort.

Stenographic and clerical work has been heavier this year, and will no doubt increase.

Requests in increasing number from other State Societies and Health Departments are being received for information regarding the Public Health Hour.

There has been an increase in the number of committee meetings held at the Executive Offices in Trenton, many of which require the attendance of the Executive Secretary and a stenographer. Rentals of meeting places have been eliminated through the free use of the auditorium in our office building.

As the Executive Offices of the Medical Society become better known, more requests from our members for various kinds of information are being received by telephone and letter, and samples of our programs and plans are sent to other organizations in New Jersey and in other states.

The work in the Executive Office has been increased this year requiring considerable overtime (without extra remuneration) on the part of the staff. Most of the extra work is a direct result of the service in connection with the Public Health Hour and the E. R. A.

If the government should take over the supervision and control of medical services under some form of State Medicine, we must frankly face the fact that the Medical Society would be required to furnish the same services and records with which we are now experimenting, and we should lose the freedom we now have to change our methods quickly as our experience dictates.

Administrative supervision and control is inseparable from fiscal control, and this must be kept eternally in mind in any consideration of planned and organized service,—whether it be under the supervision of our own Society or the government or any other agency.

The members of the State Medical Society are urged to visit the Executive Offices and

make specific suggestions as to possible economies, without sacrifice of efficiency.

Field Visits to County Societies have been somewhat curtailed this year by the more frequent meetings of State Medical Society Committees. A considerable amount of work in the office in the evenings has been necessary to keep the correspondence and minutes up to date. However, most of the County Societies have been visited at least once during the year.

A continuous study is made of reports from other State Medical Societies and the A. M. A. on economic experiments and plans to furnish better distribution of medical services; and these indicate that some progress is being made in furnishing more extensive and better planned service in the lower economic groups of the people, in some places.

It is encouraging to see that several of the *essential principles* stressed by organized medicine have been accepted in the report of President Roosevelt's Committee appointed to study and recommend measures to provide greater economic security.

Papers explaining the work of the New Jersey Medical Society have been published this year in "American Medical Association Bulletin" *(December 1934)*, "American Medicine" *(Oct. 1934)*, "N. J. Sanitary and Health Association" *(Proceedings 60th Annual Meeting Nov. 16 and 17, 1934)*.

LEGISLATIVE SUPERVISION

The Executive Secretary has attended practically all of the sessions of the Legislature and has studied the bills of interest to the medical profession. Bulletins showing the number and purpose of each important bill of medical interest have been issued at intervals to the key men and to the Component County Medical Society Secretaries.

UNITY OF AIMS

The work carried on in the Executive Offices is a reflection of that done by the Officers and Committees of the State Society and its Component County Societies.

Plans for work and reports of accomplishments, flowing through the Executive Offices where they are classified and distributed, and copies filed for future reference, promote unity of purpose and coördination of effort. Information regarding every phase of Medical Society activities is available or can be found after a brief search.

Coördination and study of special items in the collected material at the Executive Offices shows the progress already made and affords a concrete demonstration of The Medical Society of New Jersey in action.

Respectfully submitted,

LEROY A. WILKES,
Executive Secretary.

March 25, 1935

REPORT OF THE SECRETARY

By J. B. MORRISON, M.D., Newark, N. J.

To the President, Officers and Members of the Medical Society of New Jersey:

We open today the 169th session of our Society. We are proud to report that our Society continues to be one of the outstanding State Societies in the American Medical Association. We receive scores of letters from the other State Societies inquiring about the activities of our organization, especially along social and economic lines.

This House of Delegates, based on the 1934 Official List and the increase in membership since, consists of:

Elected Delegates	194
Trustees	17
Fellows who are not trustees	9
Members of the Judicial Council, who are not Delegates	4
This makes a total of	224

I would advise the secretaries and officers of the component societies to make inquiries as to why there are so many absentees at this session, with a view of electing more active delegates in the future.

Our total membership on the 1934 official list was	2757
Our total membership on the 1935 official list is	2802
Associate members listed to date	175
Total present membership	2977

We feared that the continued depression would make a considerable change in our figures but are glad to report a gain in both Active and Associate members of:

Gain in active members	45
Gain in associate members	56

We have lost by death 41 members. Among these the most outstanding loss was that of

Dr. Alexander Marcy, Jr., of Burlington County, President of this Society in the year 1905, and Dr. Victor Mravlag, of Elizabeth, a former President of the Union County Medical Society.

As a matter of economy I have reduced the usual number of visits to the various component societies, but have been exceptionally active in other fields. In March I attended the Governor's Conference on Crime. This was attended by over 2,000 delegates. If the recommendations of this conference are carried into appropriate legislation and the suggestions for the character building and moral instruction to children and the supervision of activities are carried into effect, there will be a large decrease in juvenile delinquents, the class from which crime draws a large proportion of its recruits.

As President of the New Jersey State Tuberculosis League I am endeavoring to forward the campaign for the tuberculous testing of school children and the x-ray examination of the lungs of reactors.

It was my pleasure early in April, at the invitation of the Atlantic County Medical Society, to broadcast to the laity a message on the so-called social health insurance measures being introduced in many state legislatures. It should be the endeavor of our profession to see to it that the laity are thoroughly informed as to the dangers of this program. It will affect the common people far more than it will the members of our profession.

I am compelled to report that there is a general and persistent demand that the dues of the State Medical Society be reduced. While we have an excellent showing in membership at this time both in new and associate members, we have lost during the year, over 200 old members who were with us from 5 to 10 years. This does not indicate dissatisfaction with our activities, but shows that with the continued hard times and the reduction of income in many cases up to 75 per cent, these members are no longer able to pay the dues assessed by the State Medical Society on the Component Societies.

Respectfully submitted.

J. B. Morrison,
Secretary.

REPORT OF THE BOARD OF TRUSTEES

By Wells P. Eagleton, M.D., Chairman, Newark, N. J.

In the opinion of the Chairman of the Board of Trustees, the outstanding principle of Dr. Ely's Presidency has been his constant attempt to have all actions of the different officers of the Societies coördinated, and approved by all members of the different committees with the view that a larger and ever-increasing number of members from all parts of the State, not only will be brought into the active working of the Society, but feel that they are important and of assistance to it.

With this in view, Dr. Ely has personally consulted the Chairmen of the Board of Trustees as well as various members of the Board, and the Chairmen of the different committees before deciding on any action whatsoever; and then has had their suggested action endorsed by the Board of Trustees.

This is a continuation and a most encouraging enlargement of the policy, first enforced last year by the personal energy and self-sacrifice of Dr. Quigley, of having a large number of committees, each of which had definite duties to perform, and was expected to call frequent meetings of all its members in their coöperation with the officers.

This coöperation will, I am sure, be of lasting benefit to the Society, for while it has entailed much additional labor on the part of the President, Dr. Ely, it has made a large number of men coöperate, and by interesting them, has made them accept responsibilities which they otherwise would have avoided or even completely neglected.

The Board of Trustees has become what it must be as an efficient organization for the safe-guarding and furtherance of the interests to the medical profession, namely, a Cabinet of the President to advise and to assist him, but never to conspire or render aid to efforts to undermine his authority or his actions.

The House of Delegates, at the last Annual Meeting by an overwhelming voice, voted condemnation of all efforts at hindrance to the actions of its duly elected President by others to further the special interests of any group or individual not in sympathy with an aggressive policy by the Society.

The Board of Trustees has held seven (7) meetings since the adjournment of the State Society, its interests centering in putting into

effect the Physicians' Lien Law passed during the Presidency of Dr. Quigley.

As early as the meeting of June 24th there was a variance of opinion, some holding that the provisions of the Law were ineffective until the requirements were fulfilled by the Medical Society's obligation to set up fee schedules. Other members felt that the provisions of the Bill were effective from the time it received the signature of the Governor. It was then moved that the sub-committee of the Welfare Committee on Physicians' Lien Law be designated a committee of the Board of Trustees to make a report.

A meeting was held on July 22nd and the Board of Trustees decided that in the enforcement of the Physicians' Lien Law the following five points were to be considered:

1. Severity and nature of the injury
2. Amount of time given in treatment
3. Skill and reputation of attending physician
4. Physical recovery of the patient
5. Monetary settlement.

On September 16th the Chairman of the Physicians' Lien Law Committee stated that his committee had made a very thorough and comprehensive study of this whole matter; that it had consulted all sources of information having any bearing on this subject; and that it had unanimously arrived at a decision that a single schedule would be better adapted to the welfare of the members of the State Society, and this he recommended.

The joint committee, that is, the committee on Physicians' Lien Law and the special committee appointed by the Board to meet with it, agreed with his committee and accepted the single fee schedule after careful consideration of the reasons for the decision. Being under the impression that this joint committee was authorized to put the schedule as adopted into effect, the Chairman of the Physicians' Lien Law Committee so reported to the County Societies. It was reported that Atlantic County had already taken the necessary steps to put the schedule in operation.

On October 28, 1934, Dr. Ely reported on the activities of the Committee on the Physicians' Lien Law. Each county society was in favor of the fee schedule as recommended; Atlantic County had already put its fee schedule in operation and Somerset County was going through the steps as laid down by law. Shortly following this the Bar Association filed Writs of Certiorari in two counties.

Then on December 16th a meeting of the Board of Trustees and of the Special Committee, as well as the Chairman of the Welfare Committee, reviewed the progress toward the enactment of the Lien Law, and pointed out the legal points in which it was felt the Bar Association had real strength in its opposition to the law, and those which were considered weak and of minor importance.

Senator Leap advised a meeting between the Medical Society representatives and the groups in opposition, so that the view-points of each might be mutually discussed in the hope that such a meeting would lead to a common ground for agreement. It was advised that those counties which have not filed their fee schedule proceed with this regardless of the present controversy.

The Board of Trustees then adopted the following authorizations:

1. Each county society to proceed with the filing of its fee schedule with the County Clerk.

2. The appointment of a committee of the State Society, which is to confer with a committee of the State Bar Association and the insurance companies.

3. The preparation of special forms and notice of reservation to be used in all counties.

Early in January the Special Committee of the Trustees and the Special Committee on the Physicians' Lien Law met, and on January 27th a conference was held and decided that a law should be drafted providing that the Insurance Carriers should set aside 25 per cent of the settlement to cover the physician's fee. These changes received the approval of all representatives of all the groups concerned. Senator Leap was to draw a new bill incorporating these new provisions and was to be notified upon its completion, and a copy was to be sent to him.

Since this agreement between the three groups was made, an objection was raised by the Insurance Carriers, who demanded that the amount of the settlement to be reserved shall be 33 per cent, instead of 25 per cent, this to include the claims of the hospitals under their lien. Such an agreement was highly undesirable and was opposed unanimously by the Board of Trustees.

In the National Security Program a communication replying to one from the American Association for Labor Legislation was prepared by President Ely in conference with Dr. Snedecor, copies of which were sent to President Roosevelt, Secretary of Labor Perkins, Dr.

Harvey Cushing, the Associated Press, and J. B. Andres, Secretary of American Association for Labor Legislation.

During the past year the Board of Trustees gave a great deal of time discussing the possibility of the reduction of the fees of the members of the Society; but at the present time it appears as if the activities of the Society would be materially impeded by any reduction of them.

At the completion of his term, Dr. Ely can feel happy and we do hereby congratulate him, in the knowledge that today for the first time in years, every officer as well as every employee, and all committees feel their responsibilities for concerted action under the leadership of the duly elected President, as was first propounded in the formation of the principles adopted in 1932, "To make the Society with all its activities center in the President during the year of his presidency" (Transactions of the House of Delegates, 1932, page 24).

At the expiration of his second term as Chairman of the Board of Trustees, it is a source of personal gratification to him that under the regimé of the last two Presidents, he has been privileged to be of some assistance to them in bringing back the leadership of The Medical Society of New Jersey for the protection of the political, economic, and ethical interests of the licensed physicians of New Jersey, which, in his opinion, must continue to be the main object for the Society's existence.

WELLS P. EAGLETON,
March 25, 1935 Chairman, Board of Trustees.

REPORT OF THE TREASURER

By ELIAS J. MARSH, M.D., Paterson, N. J.

To the House of Delegates:

There is little point to a preliminary report at this time, so long before the end of the fiscal year, which does not close until May 31. In fact, the formal report to be presented at the annual meeting on April 30, will, on that account, be only a preliminary one. It should be sufficient for the present to say that the Society's finances are running a normal course about like the average of other recent years at this season. The report published in The Journal last May, page 262, will present the condition as acurately as any made up now could do. A final report will be ready on June 2nd, to be presented to the Trustees and published in The Journal at the earliest opportunity thereafter.

E. J. MARSH,
Treasurer.

March 12, 1935.

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

By CHARLES J. MURN, M.D., Paterson, N. J.

The annual report of the committee on the Constitution and By-Laws will simply state that nothing has been refered to this committee during the past year. The codification of the Constitution and By-Laws to date has been accomplished and published in the November Issue of the Journal.

I would suggest that a copy of the Constitution and By-Laws be sent to the President and Secretary of each component County Society.

Respectfully submitted,
CHARLES J. MURN,
Feb. 23, 1935 Chairman.

COMMITTEE ON FINANCE AND BUDGET

By HARRY R. NORTH, M.D., Trenton, N. J.

The Committee on Finance and Budget cannot submit a report for the April Journal, inasmuch as a report will not be available until after the budget is made up.

HARRY R. NORTH, *Chairman.*

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIP

By T. W. HARVEY, M.D., Orange, N. J.

The Committee on Honorary Membership will have the pleasure this year of recommending the name of an outstanding member of the Medical Society of New Jersey for election to honorary membership; one whose contribution to scientific medicine richly entitles him to this distinction.

To disclose the name of the nominee in advance of its presentation to the House of Delegates would take away the element of surprise to the recipient of the honor.

Respectfully submitted,
THOMAS W. HARVEY, *Chairman,*
FREDERIC J. QUIGLEY,
EPHRAIM R. MULFORD.

REPORT OF THE PUBLICATION COMMITTEE

By HENRY C. BARKHORN, M.D., Newark, N. J.

To the House of Delegates:

The Publication Committee has had its most successful year. There were regular monthly meetings, with several special meetings. These meetings were all well attended. Because of their enthusiasm, Dr. Ely and Dr. Eagleton were helpful in enabling us to publish an up-to-the-minute outline of all activities.

Our contacts with the Woman's Auxiliary and the County Secretaries and Reporters have been more coöperative than ever before; and in addition we have given a great deal of publicity to local medical societies throughout the State.

THE JOURNAL

The major activity of the Publication Committee has been the preparation of its monthly publication, *"The Journal of The Medical Society of New Jersey"*, which was founded on September 1, 1904, and is now in its thirty-second annual volume. The Journal has had the first place on the program of every meeting of the Publication Committee. Its editorials have received special attention, the Editor having submitted a copy of each one to the committee before the meeting. All scientific articles have been considered, and a choice of articles and announcements from outside sources have been made.

The committee has functioned actively and harmoniously, in order that The Journal should worthily reflect the work and ideals of the members of The Medical Society of New Jersey.

STATISTICS

Last year the Publication Committee reported that it planned to publish about 750 pages of reading matter instead of nearly 1000 as formerly. The number of pages printed in The Journal during the year 1934 is shown in the table:

NUMBER OF PAGES IN THE SEVERAL DEPARTMENTS OF THE JOURNAL IN THE YEAR 1934

Month	Editorial	Original Articles	State	Local	Totals	Adv.
January	6	37	8	11	62	26
February	6	36	4	16	62	26
March	5	38	4	15	62	26
April	7	38	3	14	62	26
May	6	0	45	15	66	38
June	5	32	20	7	64	26
July	6	44	6	6	62	26
August	6	44	4	4	58	30
September	6	41	7	2	56	28
October	6	25	25	4	60	28
November	6	26	9	17	58	30
December	6	29	2	19	56	32
	71	390	137	139	728	340

Reading	728	
Advertisements	340	
		1068
Supplements:		
May, List of Members	56	
August, Transactions	56	
		112
		1180

The most significant change disclosed by the table is the great increase in the space devoted to activities of the State Society. Not only has the increase been in the number of the activities, but also in the coöperation of the officers and committee chairmen in reporting them. Furthermore, the close association of the Editor and the Executive Secretary in the

executive offices is to their mutual advantage in the exchange of information, and also to the benefit of the Society.

The county societies have reported a greater number of activities than ever before. Their reports were indexed for the first time, the space required being greater than that for any other department of The Journal. The number of county society meetings held during the year was 143, of which 108, or 70 per cent. were reported in The Journal. Credit for promptness and efficiency of reporting belongs to the smaller as well as the larger counties. The report of each monthly meeting in Gloucester County, which stands fifteenth in the number of its members, is always mailed to the Journal on the next day.

Every effort is made to give publicity to the activities of the smaller societies. A striking fact is that two of the smallest county societies—Salem and Cape May—enroll 80 per cent of their members as officers or committeemen (Journal Feb. 1935, p. 59).

We have continued our effort to place articles by New Jersey doctors in a prominent position in The Journal, and are contemplating a department in which articles by New Jersey doctors published elsewhere will be abstracted.

A change in the arrangement of The Journal was made a year ago. Additional improvements made during this year have consisted in changed headings of pages in order to make our Journal uniform with other outstanding publications, and as a help to readers and librarians. We also improved the cut of the Seal of the Society, and published more long abstracts of articles received from County Society meetings.

Because of the splendid and thoughtful work of our Editor, Dr. Overton, and the many helpful suggestions of our Executive Secretary, Dr. Wilkes, the editorials have been especially constructive and thought-provoking. If you reread those of the year just passed, you will be amazed at the number of pertinent topics discussed.

We hope the new boxes for filing the Journals will be used extensively, for we thoroughly believe our Journal is the most helpful of all State Journals, and that it should be carefully preserved for future reference.

Our financial condition is excellent. The economies inaugurated in the recent past have been continued. We think we are giving the members the best possible Journal at the lowest possible cost, and would respectfully suggest the same amount as last year, $12,500.00, for our budget.

The following is a summary of our finances with estimates for the balance of the Journal fiscal year:

JUNE 1, 1934-MARCH 15, 1935

RECEIPTS

Receipts sent to Dr. Marsh, Treasurer	$ 5,528.98
On hand in bank	333.10
Receipts to date	$ 5,862.08
Estimated receipts to June 1, 1935	1,495.74
	$ 7,357.82

EXPENSES

Printing and Mailing Journal	$ 9,072.21
Reprints	108.50
Addressograph	26.55
Code Authority	10.00
Editorial office, Journal expenses	353.15
Expenses to date	$ 9,570.41
Estimated expenses to June 1, 1935	1,871.77
	$11,442.18

COMPARATIVE STATEMENT

	1933-34	1934-35
Receipts	$ 7,354.07	$ 7,357.82
Expenses	11,917.34	11,442.18

PRESERVE YOUR JOURNALS

The great increase in the activities of the medical society, and the frequent inquiries regarding them make it extremely desirable, and even necessary, that each member shall keep his Journals in a definite place where he can consult their records. The Publication Committee proposed that the Society should prepare paper boxes, each to hold a year's volume (Journal, Jan. 1935, p. 3) and should distribute them to the members through the county societies. On receiving the approval of the Trustees, the Society gave a trial order for 300 boxes, 100 of which were soon taken by one county society. A box is available to every member at the cost of 30 cents to cover the cost of their manufacture.

THE ANNUAL REPORTS AND TRANSACTIONS

The Publication Committee has the supervision of the publication of the Annual Reports of the Officers and Committees of the State Society in accordance with the action of the House of Delegates on June 10, 1927, as follows:

"The report of the Board of Trustees and the reports of committees which are to be acted on in the sessions of the House of Delegates shall be printed in The Journal a month before the meeting, in order that the delegates may be acquainted with the business that is to come before them."

THE TRANSACTIONS

The duty of publishing the Transactions of the House of Delegates and the minutes of the Annual Meeting of the State Society also devolves on the Committee on Publication. It has been the custom to print the entire stenographic report of the remarks of every speaker before the House of Delegates. Many of the remarks are made entirely impromptu, and often in the heat of debate and without a complete verification of facts and opinions. During last year the officers of the Society have frequently had occasion to consult the Transactions of the past ten years, and have encountered not only extravagant statements but also important inaccuracies. A serious attempt made last year to edit the remarks to be recorded in the Transactions met with a favorable response from the speakers; but the semi-official sentiment was also expressed that whatever was said should be printed, on the ground that "it has always been done that way". The Publication Committee feels that the House of Delegates should authorize the Publication Committee to edit the impromptu remarks of the speakers for the purpose of not only saving the speakers some degree of embarrassment, but also for the sake of accuracy.

The committee therefore recommends that the House take the following action:

"Resolved, That the House of Delegates authorize the Publication Committee to edit remarks made during debates, but always with the consent of the speakers and of the officers of the House."

THE CONSTITUTION AND BY-LAWS

On June 7, 1934, the House of Delegates authorized the Publication Committee to prepare and print the Constitution and By-Laws as revised to date (Transactions 1934, p. 39). This task involved a study of the Transactions beginning with those of 1929, when the last printing of the Constitution and By-Laws was made. The revision was executed during the Summer and Fall of 1934, under the supervision of Past President Quigley and Secretary Morrison, and was printed in The Journal of October 1934, page 586. Reprints were also made for the use of the officers, and arrangements were made with the printer to preserve the type so that future revisions could be issued at a minimum of cost.

The booklet of the revised Constitution and By-Laws is arranged with paragraph headings in bold type for easy reading. A two-page index is also included in order to facilitate locating the references.

STUDIES OF RECORDS

The Editor, as the executive officer of the Publication Committee, has been frequently requested to make researches into the records of the Society, and to prepare briefs and analyses for the use of the officers and committees. The Editor has been handicapped in these researches by the absence of records except those which are printed in a formal way in The Journal and Transactions. But with the establishment of the Executive Offices of the Society, the minutes of committee meetings and conferences are kept on file, in a form adapted to easy reference. The amount of necessary records that have accumulated during the past year is surprisingly large, and will enable the officers to avoid a duplication of action which has been inevitable when new committees and officers have assumed their duties with no knowledge of the past action of their predecessors. The value of studies of these records will be increasingly evident with their availability and classification.

The Publcation Committee has adopted the policy that published reports in The Journal shall include the dates and places of the meetings and shall carry cross-references to previous records in The Journal, and Transactions. The Publication Committee has also approved the preparation of complete indexes of all items in The Journal, especially the actions taken by county societies on recommendations made by the State Officers and Committees.

JOURNALS OF OTHER STATE SOCIETIES

The medical profession of the entire United States is confronted with common problems which state societies have attempted to solve, each in its own way. The state journals are the only practical sources of information regarding the projects of the several state societies, whose experiments and philosophies are of great value to the officers of The Medical Society of New Jersey.

The Publication Committee therefore approves the policy that the Editor shall read the journals of the other states and shall make notes and indexes of those reports so that they may be readily available.

It has been the custom to make clippings from the exchange journals, and then throw the journals away. But during the past year, the policy has been adopted that every journal shall be kept intact; and that when an article is to be used, it shall be copied, so that the journal may be preserved whole.

The filing of the exchange journals and their preservation has become a serious problem.

A year's volume of a state journal weighs five or ten pounds, and occupies an amount of space that is not available in the Executive Offices. The Publication Committee has therefore made arrangements with the Academy of Medicine of Northern New Jersey to take over the journals and file and preserve them in its building in Newark where they will be available to any member of the State Society.

BOOK REVIEWS

Solicitations are frequently received from authors and publishers that The Journal shall publish reviews of new books. The Publication Committee has therefore made arrangements that the Library of the Academy shall assume the responsibility to secure reviews of new books; and in return for the service, that the books shall be deposited in the Library of the Academy, each with a card inscribed "The Property of The Medical Society of New Jersey". These books will be available to all members of the State Society.

The compelling reason for making this agreement with the Academy of Medicine is that Newark is a great medical center in which specialists capable of making scientific reviews are available. The Academy also has the organization available for making the reviews.

The Publication Committee suggests that the House of Delegates approve its plan for conducting a Book Review Department in The Journal.

OBJECTIVES

The Journal is designed to set forth the activities of The Meical Society of New Jersey at work. The fundamental activity of the Society has always been, and still is, that of *Graduate Education,* in order to prepare the individual physician to treat the individual sick patient.

A modern objective is that the *Medical Society* shall be the medical advisor of the *community*—the *State Society* in all statewide projects, and the *County Society* in all local health activities. This means that every member of a county society has *civic* duties to perform, in addition to his *private* duties to his individual patients.

The advice which The Journal reiterates to physicians as well as lay health workers is "Consult Your County Medical Society".

Respectfully submitted,

HENRY C. BARKHORN, *Chairman,*
EDGAR J. ILL,
LINN EMERSON,
J. B. MORRISON,
LANCELOT ELY,

Committee on Publication.

REPORT OF THE WELFARE COMMITTEE

By THOMAS B. LEE, M.D., Camden, N. J.

To the House of Delegates:

To date, March 1, 1935, the Welfare Committee of The Medical Society of New Jersey has had two meetings, which were reported in the Journals of October 1934, p. 599, and March 1935, page 161.

At the first meeting, September 23, 1934, the committee was organized and the program for the year outlined by President Ely.

At the second meeting, February 3, 1935, a preliminary report was received from Dr. Alexander on the progress of the Medical Practice Act to date. At this meeting the Act had not received sufficient study for final action by this committee.

Dr. Ely reported that circumstances had created an emergency in the matter of The Physicians' Lien Law. Because of the emergency, he appointed a committee from the Board of Trustees and included the Chairman of the Lien Act Schedule Committee and the Chairman of the Welfare Committee.

As the time for introducing new bills was short, this committee met and with the aid of counsel devised a new Lien Act, which was presented to the Legislature. The Welfare Committee endorsed the action of President Ely in meeting this emergency.

Reports were received from the Public Health Committee and from the Legislative Committee.

Bill A-28, which continues the exclusion of professional examining boards from purview of State Budget Act, was endorsed. Bills A-67, A-68 and A-69 were endorsed in principle. Bill A-182 was opposed. Bill A-196 (swimming pools) was endorsed in principle.

Respectfully submitted,
THOMAS B. LEE, *Chairman.*

REPORT OF THE SUB-COMMITTEE ON LEGISLATION OF THE WELFARE COMMITTEE

By D. LEO HAGGERTY, M.D., Trenton, N. J.

To the Welfare Committee:

The Legislative Sub-Committee of the Welfare Committee reports a successful year.

The Physicians' Lien Bill (S-134) has passed both the Senate and the Assembly, and awaits only Governor Hoffman's signature to become law. This bill was the outgrowth of the opposition of the Bar Association of New Jersey which, through Writs of Certiorari, endeavored to test the constitutionality of the present Physicians' Lien Law (Chapter 109, Laws of 1934).

A series of conferences held by representatives of the Lien Law Committee and the Board of Trustees for The Medical Society, the Bar Association of New Jersey, and the Insurance Carriers of this State, resulted in an amicable agreement to introduce a new bill (S-134) which is, we believe, a more satisfactory and workable agreement for protecting the physician against loss than the present law.

Assembly Bill 28, to preserve to the Professional Boards their funds collected, was also successfully passed in the Senate and Assembly, and now awaits only the Governor's signature to become law.

The Legislative Committee actively supported both of these bills and were instrumental in getting them passed.

The Chiropodist Bill (A-150) and the Beauticians' Bill were both vigorously opposed until properly amended; and both these bills, so amended, are still in Committee in the Senate.

The Osteopathic Bill (A-238) is a vicious piece of legislation, and has been consistently and successfully opposed so far. The bill has never gotten out of the Public Health Committee in the Assembly where it was first referred upon its introduction. Much credit is due to Dr. Newcomb, Majority Leader in the Assembly, and to Dr. Bien, Chairman of the Public Health Committee in the Assembly, for this successful effort.

Mr. Pasco, who in Dr. Newcomb's absence acted as Majority Leader in the Assembly, has been an able ally of the medical profession.

Others too numerous to mention individually have voted consistently for bills supported by The Medical Society of New Jersey.

In the Senate, Dr. Blase Cole has been our able ally, and Senators Stout, Wolber and Leap have led a majority of the members of the Senate large enough to insure our success this year.

Other bills of interest have been called to the attention of the Key Men in each County, the Welfare Committee, and the members of the Society in our three Legislative Bulletins, and in our Journal and Committee reports.

The Key Men have responded well, but we are glad to report that the necessary demand upon them this year was not so sustained and prolonged as last year since the opposition was less marked and sustained.

Respectfully submitted,

D. LEO HAGGERTY, *Chairman,*
DAVID W. SCANLAN,
EDWARD H. COWARD,
A. H. COLEMAN,
SAMUEL ALEXANDER,
CHARLES H. MITCHELL,
D. S. POLLAK,
FLORENTINE M. HOFFMAN,
THOMAS B. LEE,
WILLIAM H. ARESON,

REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

By THOMAS K. LEWIS, M.D., Camden, N. J.

To the Welfare Committee:

The outstanding economic problem of the year has been that of the menace to the profession of *compulsory health insurance,* which has been definitely in the mind of the Federal Administration. This threat to sound principles of efficient and adequate medical service has been aided and abetted by considerable and voluminous propaganda turned loose by various socialistic organizations. We are happy to

report that the menace for the present seems to be waning. Very little enthusiasm has been demonstrated by that portion of the laity which is chiefly concerned over state controlled medical service. Organized labor, while expressing the hope for some adjustment of medical costs to fit the pocket-book of the worker, has in no way expressed approval of the idea of compulsory health insurance.

In planning to meet this problem many meetings and conferences, both state and interstate, have been held. The old Tri-State Conference was rejuvinated and enlarged to include many States in the northeastern section of the United States. The culmination of nationwide activity was expressed in the special executive session of the House of Delegates of the American Medical Association, held in Chicago on February 15-17, 1935, at which meeting organized medicine in this country took a definite, unequivocal stand against any form of compulsory sickness insurance.

It has been somewhat disappointing that in all these meetings and conferences, and with all the experimentation in "plans", there has been no clear-cut statement of the problem with which organized medicine is faced. Compulsory sickness insurance and all the substitute schemes so far suggested are merely palliative measures. *Symptoms* are being treated, but no concerted effort has been made toward *correction of existing pathology*. The menace of governmental action seems for the time being to have been averted; and with a solid unity of medical opinion it can, no doubt, be permanently suppressed. However, the condition that has given rise to this effort at regimentation of medical service, if not corrected, will continue in the future to stimulate efforts for governmental control of our profession.

THE PROBLEM

Fifty years ago the physician, with the skillful use of his five senses and his medicine kit, was sufficient unto himself. In the same era the hospital, or nursing home, was an institution established as the most economic and convenient means of securing medical service for the indigent. Since that time medicine has taken on rapidly a more scientific aspect which has resulted in the development of elaborate laboratory technic and many instrumental means of diagnostic precision. Surgery has developed apace, making necessary the installation of costly operating room equipment and the use of a multiplicity of new and complicated instruments. The field of medicine, as a result of this quickening of scientific consciousness, has been subdivided into many fields, with the production of an increasing number of specialties. Chemistry, feeling the impetus of Erlichs' epoch-making work, has been juggling old drugs all over the chemical lot, with the production of a host of new and inordinately expensive remedies. As a result of these developments the present-day physician feels himself dependent upon the laboratory, the specialist, the x-ray, the physio-therapist, the electrocardiograph, etc., to a very large extent; while his credulity has resulted in the introduction into his therapeutic armamentarium of a deluge of overpriced proprietary remedies. The ordinary doctor, the family physician, who should be the cornerstone of the medical structure, is becoming almost an archaic institution in the metropolitan areas. The specialties, offering better fees and more comfortable hours, are attracting a high percentage of the younger physicians. The hospital, from its original humble estate, has evolved into a centre for the housing of expensive equipment, where can be obtained the last detail of perfection in surgical technic, the highest refinements in diagnostic procedures, and all forms of most modern treatment. The result of this trend is that, when faced with serious illness, the low-wage class, which constitutes 80 per cent of the population, finds it impossible to meet the cost of medical care. Consequently our wards and dispensaries are full to overflowing with people who should be paying their way, but who are forced to accept this kind of service as charity. In a word, the cost of serious illness on a pay-as-you-go basis is out of the reach of the largest class of our citizens. Through this increased cost to the patient the physician has not profited, and our hospitals are showing steadily increasing deficits.

The problem is not that of finding a means of enabling the low wage earner to meet the increased cost of medical care; but rather *to discover means of adjusting modern medicine to society as it exists*. It is not so much a matter of facing a new social order, as it is of adapting a new order of the practice of medicine to a social fabric already in existance. Nor does the depression have anything to do with the problem, beyond the fact it has aggravated the difficulties of both the donor and the recipient of medical service.

The Sub-Committee on Medical Practice has been urged to prepare a plan to be held in readiness in the event of compulsory sickness being legislated into being. After careful consideration the committee has come to the conclusion that the formulation of any such plan at the present time is inadvisable. It has been

pointed out that New Jersey, because of its small area, would provide an excellent laboratory for experimentation. While this may be true, yet New Jersey presents the same wide diversity of local conditions that obtains in the United States as a whole, ranging from the most rural of communities, to metropolitan areas, thus rendering impractical the application of any one plan.

Any insurance plan with the scope suggested in the Epstein Bill would be far too costly. The British system, undoubtedly the least objectionable of any national scheme in practice, has proven excessively expensive, and will very likely be abandoned in the not distant future. The Michigan plan while idealistic is quite impractical in its estimate of executive cost. Conferences with officials of an insurance company dealing in small premiums and small claims reveals the fact that operation and executive expenses run into high percentages. In any such plan it is estimated that fifty per cent or less of the money involved would be returned in actual medical service.

While no *plan* is now presented, planning for the *future* is much to be desired. Such planning, in order to be constructive in character, must be directed toward the *adjustment of modern scientific medicine to fit the pocketbook of the working man.* Certain sacrifices will be requisite of the physician, but such sacrifices that in the long run will add to rather than detract from, his economic security and professional independence.

RECOMMENDATIONS

The suggestions to follow are offered as basic ideas for further study and amplification, it being understood that a more detailed exposition will be prepared for presentation to the House of Delegates at the forthcoming Annual Meeting.

Among the many propositions that suggest themselves as being of possible remedial value, and at the same time practicable of application are the following:

1. Encouragement of the family physician.
   a. More stress in medical schools and hospitals in preparation for general practice.
   b. Better relationship between the general man and the specialist. (There has been a growing tendency for the specialist to accept patients without the sanction of or regard for the family physician.
2. A modified fee schedule for laboratory work, x-ray examinations, and other instrumental diagnostic procedures applicable to patients in the low-wage class. (At the present time there is no shortcut between full fee and absolute charity. Consequently innumerable cases are referred to the free clinic as the only means of securing the necessary study.)
   a. Alternative, freer use and larger development of health department facilities.
3. Special wards or ward rates for patients of the low-wage class, wherein the physician or surgeon might collect a considerably modified fee. (This would bring some remuneration for a vast amount of work now being done without any return to the physician.)
4. Hospital financing. The feasibility of instituting some form of voluntary hospitalization insurance for members of the low-wage class is to be considered. This principle has proven effective in Great Britain, in the Hospitals' Contributory Funds, in having taken many of the British hospitals out of the red. It is understood that such insurance would apply to hospitalization in the strict sense of the word and not to professional services.
5. Modified consultation and surgical fees for patients in the class under consideration.
6. The possibility of adjusted nursing rates for patients of the low-wage class who have taken advantage of hospitalization insurance.
7. Reduced prescription charges for patients in this class, some special designation to be placed on the prescription to indicate the classification to the pharmacist.
8. More extensive use of the U. S. Pharmacopeia, the National Formulary, and the New Jersey Formulary, in writing prescriptions. Coöperation of physicians in this matter will aid tremendously in reducing the cost of prescriptions by modifying the present large overhead of the pharmacist.

   Attention is called to the New Jersey Formulary which is now an accomplished fact. As previously announced, this formulary has been devised by coöperation with the State Pharmaceutical Society for the purpose of standardizing and providing ethical nomenclature for preparations of useful new and non-official remedies until such time as they are included in the U. S. P. or N. F. At the coming annual

convention of the New Jersey State Medical Society, a display of these preparations will be on exhibit. It is earnestly urged that the physicians of the state give their support to this new formulary by using it freely.

9. The feasibility of forming a Bureau of Economic Investigation and Adjustment, similar to that now in operation in Washington, D. C., not only for approving eligibility of applicants for the special privileges of the low-wage class, but also for assistance to the hospitals in establishing eligibility for free ward and free dispensary service. Such a bureau would be maintained by joint support of organized labor, hospitals, various charities, and the several branches of the healing art.

Obviously the application of many of these suggestions will require time, detailed study, and many modifications, in order to fit them into existing institutions of the various communities. Most important of all will be the need for sympathetic coöperation with all of the parties involved, and the selling of the idea to hospitals and labor. Experimental set-ups will be the most effective means of demonstrating the value of any such plans, and it must be apparent that an enormous amount of work will be required in perfecting them. Provided the general outline meets with the approval of the House of Delegates, the Sub-Committee on Medical Practice is willing to undertake the work.

Other miscellaneous matter under consideration by the Sub-Committee on Medical Practice have given rise to the following recommendations:

1. That advertisements in medical publications, such as the State Journal and County Bulletins, by commercial establishments doing medical work in competition with the physician be discouraged. Examples of this type of advertisement appear in the State Journal of the Clinical Laboratory, Newark, M. P. Popper, Newark, and in the Hudson County Bulletin of Mr. Winchell's offer of "Complete Medical Analysis".

Similarly it is recommended that commercial exhibits of medical men should conform to ethical standards. An example of such violation was Dr. Kieth Kahn's commercial space advertisement in Atlantic City, 1934, of his plastic surgery hospital in New York City.

A dignified standard for advertisements in our Journal should at all times be maintained.

2. That the present set-up for medical service under the Emergency Relief Administration be perpetuated, at the termination of the present emergency, as a means of providing such service for the indigent in normal times.

Respectfully submitted,

THOMAS K. LEWIS, *Chairman*,
EARL LEROY WOOD,
H. B. WILSON,
A. ANDERSON LAWTON,
CHESTER I. ULMER.

REPORT OF THE SUB-COMMITTEE ON WORKMEN'S COMPENSATION

By DAVID A. KRAKER, M.D., Newark, N. J.

To the Welfare Committee:

The Sub-Committee to the Welfare Committee, the Workmen's Compensation Act was continued with the same membership during the present year. In its previous report, (Journal, May, 1934, p. 282), the Committee made recommendations for amendments to the Compensation Law which would add in clarifying its administration, and overcome such deficiencies as have grown into the law, resulting from a lack of recognition of the importance of the part which is purely medical, in the adjudication of compensation claims.

It has been the continued hope of this committee that the report of the Legislative Commission, which was appointed in 1933, and has held hearings up to, and including 1934, would have been published; and that further, this Commission would have presented legislation which would provide in the revised Act, in whole, or in part, the recommendations made by this committee, in its 1934 report. Up to the present time such report has not been made.

PRESENT LEGISLATION

In the present Legislature, a bill was introduced, and is now pending, known as Assembly No. 1, introduced by Mr. Paul, the pur-

pose of which, according to the statement, is to "codify the fifty-seven amendments and supplements to the original act passed in 1911 and to incorporate within its terms the judicial interpretation of words and phrases of the original act for the purpose of clarity and to avoid undue litigation." The primary intent of workmen's compensation is to permit an injured employee to receive money, as compensation in place of wages, without any interruption to the family income. The present act removes the Compensation Bureau from the Department of Labor, and creates an Industrial Accident Commission under the State Civil Service Laws and transfers all of the present employees of the Workmen's Compensation Bureau to the new Commission. There is created one new commissioner. Under the present act appeals are taken to the Court of Common Pleas; under this act appeals are taken to Board of Appeals created within the Commission. The general outline of this act follows the provision of the Princeton Survey Report and follows the outline in the majority of the principal States of the Union."

From a perusal of this statement it will be definitely clear that the main purpose of the Act is to create an Industrial Accident Commission, and to perpetuate the existing Deputy Commissioners and one Referee. It contains no improvement in the administration of the Act as it relates to the medical problems involved; and the only reference in the Act directly to medical men is in Paragraph No. 28, which states, that, "The Commission is hereby authorized to appoint such doctors, referees, stenographers, clerical assistants and other employees, and to fix their duties and compensation as in its judgment is necessary to properly carry out the intention of this act, subject, however, to the foregoing civil service law."

In Paragraph No. 32 of the Act, the self-perpetuation of the Commission is provided by the statement that the "Commissioners shall have the authority to fill vacancies on the commission, subject, however, to the foregoing civil service law, and shall have the authority in like manner to increase its numbers if the proper administraton of the act necessitates it."

In the Committee's judgment this Act is likely to be successful in codifying the present law and its amendments and supplements; but no notice has apparently been given to the problem of improving the adjudication of disability compensation, in which the legal problems are rather simple, and, as stated in the original report, the abjudication of a medical fact is made solely by a layman and only in a legal determination.

RECOMMENDATION

It is urged that, unless this Act can be amended to include, in some degree, the recommendations made in the 1934 report of this Committee, the Bill be opposed in the Legislature.

DISPUTED MEDICAL BILLS

The Bill introduced by the Committee appointed by the Governor of the State of New York to amend the Workmen's Compensation Act of New York, has just been passed in the New York Legislature and has been signed by the Governor. This new Act includes many of the recommendations made by this Committee and sets up the proper association of the medical profession in the membership of the New York Industrial Accident Commission, and provides definitely for medical adjudication by Boards of Medical men. If, perchance, it is too late to amend Assembly Bill No. 1, it will be necessary for legislation to be introduced at the next session to provide for these deficiencies.

The Committee has been successful in having the coöperation of the present Commissioner of Labor, John J. Toohey; and has urged that a State Committee on Disputed Medical Bills, appointed by the President of the State Medical Society, would receive his official endorsement and he would refer to it all medical bills now in dispute for its adjudication. The Committee consisting of Dr. H. H. Kessler, representing the State of New Jersey, Dr. Charles G. Crane, representing the employers, and Dr. David A. Kraker, representing the Essex County Medical Society, has been active throughout the year, with the coöperation of the Commissioner of Labor, in the adjudication of disputed medical bills arising within the Essex district; and when the complete committee is appointed which will cover the several districts in the State, this medical problem, the Committee feels sure, will be satisfactorily solved.

RECOMMENDATIONS

It is urged that the Sub-Committee on Workmen's Compensation Law be made a

permanent committee of the New Jersey State Medical Society, and that its function shall be to study the administration of the Workmen's Compensation Act in its relation to the physician.

It is further urged that recommendations be made to the Society, at proper intervals, of such information as will improve the administration of the Law as it relates to the petitioner, employer, and the physician with the ultimate result that all will be benefited.

DAVID A. KRAKER, *Chairman*,
WILLIAM H. ARESON,
JACK BLUMBERG,
E. ROY VAN NESS,
EARL LEROY WOOD.

REPORT OF THE COMMITTEE ON UNIFORM MEDICAL PRACTICE ACT

By SAMUEL ALEXANDER, M.D., Park Ridge, N. J.

The *Committee of Uniform Medical Practice Act* has held meetings during the past year, which have been attended by Dr. Ely, our President, practically all of the members of the committee, Executive Secretary Wilkes and Mr. Grover C. Richman, attorney for the committee.

These meetings were held at the Academy of Medicine in Newark, New Jersey.

Considerale time was given to these meetings, and we have prepared a tentative Uniform Medical Practice Act.

The committee now plans to meet with representatives of osteopaths, chiropractors, chiropodists, and optometrists in order to determine their recommendations and suggestions.

After these conferences the proposed Bill will be submitted to the Welfare Committee for its consideration.

The committee wishes to thank Dr. Ely and the members of the committee for the cooperation that they have given it.

Respectfully submitted,

S. A. ALEXANDER, *Chairman*,
B. S. POLLAK,
GEORGE F. DANDOIS,
CHARLES B. KELLEY,
JAMES J. MCGUIRE,
ARCANGELO LIVA,
ARTHUR W. BELTING,
HARRY H. SATCHWELL.

REPORT OF THE COMMITTEE ON PHYSICIANS' LIEN LAW

By ELMER PETER WEIGEL, M.D., Plainfield, N. J.

To the House of Delegates:

At the last Annual Meeting it was suggested by the Reference Committee that we report our fee schedule directly to the Board of Trustee. Because the Welfare Committee would not meet during the Summer, it was thought that time could thus be saved in getting the schedules adopted by the component county societies.

Accordingly after much thought and discussion at a joint meeting of our committee and the Board of Trustees held in Trenton on September 16th, a fee schedule was finally approved.

This schedule simply stated one fee for each procedure, which was to be a maximum fee. It was felt that a range of fees would be desirable because customary charges vary in different communities, and also because the schedule should be elastic enough to cover the charge of both the specialist and the general practitioner. Yet we did not think it wise to state a minimum fee. It was therefore decided to insert the words "up to" before each maximum fee in order to imply a range rather than definitely stating it.

It was also decided at this meeting that the State Medical Society should secure the services of Senator S. Rusling Leap to aid each county society with its court hearing.

Each county society was supplied with a copy of this schedule to use as a guide in adopting its county schedule, and in practically every county the fees adopted were very similar to those suggested by the State Committee.

On October 15th Atlantic County, having advertised the schedule for the prescribed thirty days, had a hearing before two judges

of the Court of Common Pleas, and with very little opposition had the schedule adopted. On November 27, 1934, Monmouth County also succeeded in having the local court approve the fee schedule. We naturally were much encouraged by favorable action in these two counties.

On December 6 Salem County had its day in court, and there appeared representatives of the Bar Association and the Insurance Companies who had secured a Writ of Certiorari holding up the action of the Court.

A conference was then proposed by our Counsel, Senator Leap, and on January 18, 1935, a joint meeting of representatives of the Bar Association, Insurance Companies, and our Committee and members of the Board of Trustees was held at the State House in Trenton.

It was felt that it would be to the interests of all parties concerned to draft an entirely new bill, which would be an individual bill and not an amendment to the Hospital Lien Law. The new bill was not to include a fee schedule, and it was to limit the amount of the lien for medical services to 25 per cent of the amount of the settlement.

With these suggestions our attorney was instructed to draw up a new bill, which was introduced into the Legislature on January 28, 1935.

Your committee feels that with some minor changes, which will be made in conference with our attorney, this new bill will make a better law from every point of view, and one which will adequately protect the doctors' interests.

Respectfully submitted,

Elmer Peter Weigel, *Chairman,*
J. Irving Fort,
Inglis F. Frost,
Runkle F. Hegeman,
Thomas B. Lee,
Samuel Sica,
Homer I. Silvers,
Thomas J. Summey,
Joseph A. Visconti,
William L. Yeaton.

REPORT OF THE COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

By H. H. Satchwell, M.D., Irvington, N. J.

To the House of Delegates:

As reported last year, the Committee on Hospitals and Medical Education is concerned with two distinct subjects. One sub-division of the Committee has studied hospitals from the viewpoint of medical service, licensure, and standards for recogntion. This sub-committee has been in close touch with the hospitals on the one hand and with the professional staffs on the other. It has reported to the Trustees from time to time, but has been unable to devise standards which are acceptable under all conditions. The Sub-Committee is continuing its investigations and plannings.

The other sub-committee on Medical Education has made arrangements for graduate courses which were started about the first of March, and will continue until June. A report on the courses will be made later.

Respectfully submitted.

Harry H. Satchwell, Chairman.

REPORT OF THE COMMITTEE ON MATERNAL WELFARE

By A. W. Bingham, M.D., East Orange, N. J.

To the House of Delegates:

Considerable interest has been shown in maternal welfare throughout the state during the past year. More counties are taking up the work seriously, but there is still room for improvement.

Two excellent meetings have been held; one in Atlantic City on June 6, 1934, and one in Newark on January 17, 1935. Dr. De Normandie of Boston spoke in Atlantic City, and Dr. Clifford Lull of Philadelphia spoke in Newark. Many of the counties were repre-

sented in spite of the bad weather. Many reprints have been distributed to the different counties explaining how the work should be carried on.

In the Fall, the following questionnaire was sent to each county. This questionnaire includes some of the recommendations of the State Committee.

1. Is the Maternal Welfare Commission in your county functioning?

2. What has been done to improve the prenatal care in your county?

3 What has been done to encourage consultations in difficult cases?

4. What has been done to provide better hospital facilities in your county?

5. Are you checking up on the maternal deaths in your county?

Will you please be prepared to report at our semi-annual meeting on January 17, 1935, in Newark, the number of births and maternal deaths in your county for 1934; also, to subdivide the maternal deaths into three groups?

1. Obstetric deaths.
2. Deaths from abortion.
3. Deaths from medical causes.

One difficulty seems to be that many of the county societies do not consider their Maternal Welfare Commissions a regular standing committee, and do not check up on its personnel nor get regular reports from it. Every commission should be organized so that each hospital, and each part of the county is represented. The membership should be rotating, two or three members retiring, and two or three being appointed each year to serve three years. If the men are interested, they should be reappointed; and if not, new men should be tried. In this way, there are always some men on the commission who are familiar with the work.

Some of the County Commissions have their work well established. They have regular meetings at which their sub-committees report. Lecture courses for improving obstetrics in their community have been established. Many of the hospitals have regular conferences of their obstetrical staffs to which all doctors are invited. Here they discuss rules for hospital routine, as well as the best procedure in abnormal cases.

Suggestions for obstetric rules were printed in the February issue of the New Jersey State Journal, page 100. It is suggested that similar rules be adopted in every hospital. From time to time the committee hopes to have reports from different county commissions printed in the Journal, so that we may all know what is going on.

Until some of the county commissions are better organized, the State Committee does not consider it advisable to start efforts to educate the public, as the doctors should direct this work in each county and not place it in the hands of the laity.

Arrangements have been made for the State Board of Health to report the number of maternal deaths in each county each month. This report will be sent to the chairman of the State Maternal Welfare Committee, and he will report to the various County Maternal Welfare Commissions as the Board of Health cannot give this service. The commission in each county can then check up on the deaths in its own territory.

A report was read in New York last Spring on the maternal welfare work in New Jersey (Journal, August, 1934, p. 489). Since then, New York State and Pennsylvania have organized along the same lines. Your chairman has been asked for information from both states and has been glad to assist them by sending reprints and advice.

Now there has been appointed an American Maternal Welfare Committee, which is to have Maternal Welfare Committees appointed in every state in the Union, to work through Maternal Welfare Committees appointed by each county society.

We hope that when this work gets under way, the maternal mortality statistics will improve markedly; and it should give us some satisfaction to know that New Jersey was one of the pioneers.

Respectfully submitted,

A. W. BINGHAM, *Chairman,*
R. A. MACKENZIE,
P. DUBOIS BUNTING,
JOHN F. CONDON,
CARL ILL,
WALTER B. MOUNT,
NORMAN J. QUINN.

REPORT OF THE PUBLIC HEALTH COMMITTEE

By Stanley H. Nichols, M.D., Asbury Park, N. J.

To the House of Delegates:

Your committee reports that after three years of intensive effort the members of the State Medical Society are showing increasing interest in, and support of, the Public Health Plan, as adopted. National social trends have aided by convincing our thoughtful members that if the medical profession did not at once assume public health leadership, other agencies, including the government, would assume that leadership.

Our problem is no longer, "shall we assume public health leadership?" for we have already done so. Our present problem is whether or not we will meet the public health needs so efficiently and promptly that we will prevent the establishment of official administrative and service agencies in fields which are best served by the medical profession.

This task requires every member of the State Society to stand back of and share in the efforts of his County Society to provide organized services through its members. Many of our members are still playing the rôle of Rip Van Winkle, or as soldiers in the great army headed by General Apathy. About one-third of our membership are now actively participating in the Public Health Hour. This is *insufficient to demonstrate our ability and sincerity*. The other two-thirds of our members must realize the dangers that threaten us, and must take part in the hard job that confronts us, if we are to improve the situation now faced, i. e., the field of preventive medicine to be largely done by the physicians in their own offices.

It is no easy task to add this responsibility for community health needs to the private practice of curative medicine, but we must reach this goal before others replace us permanently, if we are to resist further encroachments of various forms of official medical services which now threaten us.

DIPHTHERIA IMMUNIZATION

The State Public Health Committee has held many meetings and conferences with the public health committees of the county societies and other interested community groups. The State Department of Health and its officers have been coöperative and helpful in getting our joint diphtheria immunization campaign started. The State Medical Society and State Department of Health jointly succeeded in securing an appropriation of $30,000 from the State Legislature in 1934 to provide free toxoid and vaccine for the use of our physicians in their Public Health Hour conducted in their own offices. This toxoid and vaccination material has been made easily available to all physicians by the State Department of Health at convenient centers in each county of the state. At this date over 1,000 physicians have signed the state agreement, and taken out toxoid and vaccination material, and the total of 5932 immunizations and 2858 vaccinations have been reported to March 1, 1935. This is far less than was done in schools and in Public Health Department clinics. If this plan is pushed vigorously within three years, we believe that ten times as many immunizations and vaccinations will be done annually. Our estimate is that there are still over 200,000 preschool children in this State who are not immunized against diphtheria. There will also be room for improvement in other activities in which the private physician can provide effective organized services.

In order to speed up this work, our state committee has requested each County Public Health Committee to have each physician get his *own preschool patients* immunized. To assist the physician in this respect we have designed a letter and card to be sent by the physician to his *own* patients requesting that this be done. This letter is now being distributed by the aid of the State Department of Health to our physicians. (Jour., Apr. 1935, p. 235.)

The committee has also asked, and Dr. Ireland has officially urged, boards of education and school principals to request that children be immunized and vaccinated by their *own* physicians before coming to school.

The nurses, public and private, *must be enlisted by each county society* to aid this project.

Parent-teacher associations and other lay organizations interested in child health *must be interested in promoting this health work.*

The State Department of Health *is making an effort toward getting the local health departments to act jointly* with the public health committees of each County Medical Society.

Most of the public health committees of our county societies have swung into action, and are making progress in getting the project well under way; but some of our counties still need to show considerable and prompt improvement in this project.

Our *Public Health Hour* is becoming widely known, not only in our own state, but elsewhere; and is serving as a valuable service and propaganda for our profession. Our society regards public health services as a definite responsibility of the medical profession.

PRESCHOOL SUPERVISION

The *preschool card* of The Medical Society of New Jersey has been printed and distributed to each County Society by our committee. The response has been disappointing so far. This card provides a simple method whereby each physician can *examine the children in his practice once or twice annually,* and supervise every phase of child hygiene between the infant age and the school age. It is the thought of this committee to have all baby health conferences, health departments, and similar bodies recommend in the future that each baby shall, on reaching the preschool age, be taken with this card to his family physician, and the child's health supervised before reaching school age. We have asked the State Department of Public Instructions to request that children coming to school for registration shall bring this card with them. We must do our part well. In this way our physicians through the county societies can, if they will, assume responsibility for the health of the *preschool children* of New Jersey, and fill a great public health need which now exists largely as a vacant space in the health program of almost every state in the Union.

INFANT HEALTH SUPERVISION

Our committee has requested that the Bureau of Child Hygiene through its consultant, Dr. Levy, include in its budget for the coming year an initial appropriation of $5,000 for the payment for services of properly qualified physicians in charge of baby health conferences. This amount was included in the 1935 budget and approved by the State Commissioner of Health, Dr. Mahaffey. The State Board of Health is now headed by Dr. Cosgrove, a member of our State Society. The budget is now before the Budget Commission.

Standards for baby health conferences, both public and private, in New Jersey, are being prepared by a joint study of the Bureau of Child Hygiene of the State Department of Health and our Committee. We hope by this effort that baby health conferences will be made available for the indigent and the very low income group. Also that the public health committees of our county societies shall take a very definite part in assisting in securing qualified physicians for the staffs of these well baby conferences to coöperate in their activities and help outline a proper plan and scope of baby health projects in such a way that the supervision of the health of infants in families able to pay a private physician for this sort of service shall be directed to the physician's private office.

SCHOOL HEALTH SUPERVISION

Early in the year a special sub-committee on child health was appointed by the committee to make a study of any phases of school health supervision composed of Dr. Ireland, Chairman, Dr. Kahrs, Dr. Schapiro, Dr. Hull, Dr. Lottridge and Dr. Wilkes. A digest of the report of this committee is appended. In this field it is the hope of our committee that, in addition to the variable health work done in different communities to improve the health of school children, the family physician shall once or twice a year examine these children (his own patients) in his own office and personally supervise all phases of child hygiene in each case (p. 215).

TUBERCULOSIS

A special sub-committee on tuberculosis composed of Drs. Pollak, English, Newcomb, Alexander, and Morrow has been requested to study the various demonstrations in tuberculosis mantoux and x-ray testing, etc., that have been carried on in our state with a view of appraising the results of this work, and determining the desirablity of further efforts. It is not yet clear just what the future procedure should be in this difficult field, with reference to the participation of the family physician. These studies will be continued with a view to further fact-finding and subsequent recommendations.

ORGANIZING FOR SERVICE

If we add early diagnosis examinations of adults and mental hygienic advice for all age groups to this program of infant supervision, preschool supervision, and school child examination, we have outlined a plan for possible recovery of the whole field of preventive medicine by which our fellow members in The Medical Society of New Jersey can effectively and profitably contribute to raise the physical standard of the people.

Such a plan, if vigorously pursued by our state and county societies through the intelligent coöperation of each physician member, will take several years and an enormous amount of hard work on the part of each member to accomplish; but it would mean two

important things; first, a marked improvement in the general health of the public in all ages and the appreciation and approval by the public and private health agencies of the services of the medical profession in New Jersey; and second, a total income from these sources of at least a million dollars a year to the members of our society will result from our participation in such a program. The potentiality of this plan is enormous. The public health efficiency of it is beyond dispute. Two things are demanded, i. e., hard work, and plans. It is our belief that our members can supply both, but in order for the plan to succeed each member must get into action at once, if we are to reserve for the medical profession the fertile field of public health service.

BUSINESS OFFICE OF COUNTY SOCIETY

If we are to develop these lines, each county society must develop in the immediate future more effective centralized organization, with a paid full-time assistant secretary experienced in office administration and follow-up. In other words medicine must become much better organized and more efficient in the *business* of providing medical care to meet community public health needs. Only by this method can we forestall the federal subsidies votes to provide new bureaus and agencies to do these very pieces of organized health work. By efficient methods our state and county societies can become themselves the agencies to meet public health needs through private agreements with those agencies charged officially with certain health responsibilities, and so can prevent additional agencies being set up.

Our experience with the public health hour and diphtheria immunization during the past year has shown the vital need of improved centralized county society office organization. The state society officers and committees have made a lot of progress during the past year. The county societies must make a lot more progress to speed up the program considerably. *The time is ripe.* We must take advantage of this opportunity.

RECOMMENDATIONS

The committee presents the same recommendations that were offered last year, with increased emphasis on the necessity of every one of our individual members becoming loyal teamworkers in this plan as a member of his County Medical Society. United we stand, divided we will fall, unless we *act.*

Recommendation 1. The medical societies of the state and counties must continue the assumption of leadership and responsibility for the community health needs of the citizens of New Jersey. We must preserve that personal and private relationship between physician and patient, which is the most desirable and effective plan for meeting the health needs of the people.

Recommendation 2. The societies must continue the diphtheria immunization campaign of babies and preschool children as their major project; and must show a rapid and convincing achievement, or else return to the free clinics this responsibility, without complaint.

Recommendation 3. The public health committees must continue to develop the plan of the public health hour in the physician's office, and gradually incorporate in that hour other phases of public health and preventive medical service.

Recommendation 4. The public health committees of the state and county societies shall act as clearing houses for all medical preventive services; and act as advisory bodies to any community group contemplating any type of health activity.

Recommendation 5. Sufficient funds must be provided in the state and in each county society for a central office organization to carry out this public health program.

Stanley H. Nichols, M.D., *Chairman*
Ernest G. Hummel,
Theodore Teimer,
J. Warner Knight,
Howard S. Forman,
Julius Levy,
Allen G. Ireland.

REPORT OF THE SUB-COMMITTEE ON SCHOOL HEALTH PROGRAMS

By Allen G. Ireland, M.D., Trenton, N. J.

To the Committee on Public Health:

During December and January the Chairman drafted the following outlines for consideration by the committee:

1. A set of principles underlying the modern concept of the school health program as interpreted by the Chairman from the opinions of educators, school administrators, and school physicians.

2. A set of aims and objectives, (a) for the school health program, (b) for the school physicians, accompanied by appropriate questions designed to evoke individual evaluations.

3. Two sets of questions for thought and subsequent discussion.

The committee was requested to study carefully the submitted materials in preparation for discussion meetings, because difficulty was being experienced in finding a suitable meeting date.

Individual letters were mailed in January to a selected list of school administrators and heads of physical and health education departments asking, in effect, for comments on the school health program which would indicate specific problems facing the committee.

The first meeting of the committee, and the only meeting to date, was held at Newark on February 8, with Drs. Kahrs, Lottridge, Schapiro and Ireland present.

At this first meeting, the general charge to the committee was considered in terms of scope, or the field to be studied. The discussion brought out three major divisions of the general problem. They are:

1. The selection of the school physician.
2. The program of the school physician.
3. The problems of organization and administration.

Secondary problems arose, but for the most part these fell into one or more of the above major fields. Suggestive of these are tenure of office, and the standardization of a salary scale.

The order of study decided upon corresponds to the above arrangement. Accordingly, aside from the general preliminary organization, the first meeting was devoted to a discussion of "the selection of the school physician". Specifically, this topic refers to standards governing the selection, appointment, and certification of physicians for school health work, upon a general basis of professional qualifications, and such supplementary factors of a personal nature as may later be evolved.

In view of certain current practices governing appointments, not wholly ethical in the light of medical history and ideals, it was the unanimous opinion of the committee that such practices could best be eliminated by means of *legalized certification* administered by the State Department of Public Instruction. Such is the procedure in New York and Pennsylvania. It was agreed further that boards of education and school administrators should be furnished with a code of recommendations concerning the selection of physicians for appointment. This code would embody the intangible subjective, but none the less important qualities generally defined as character, personality, interested, attitude, and adaptability. It would be accompanied by a statement of the Medical Society to the effect that the organized profession disapproves of underbidding to secure appointment, of cut rates for school work, and of conduct not in keeping with the ethics of medicine.

Concerning standards for the certification of physicians by the State Department of Public Instruction, whereby certification would be a prerequisite of appointment, the committee recommends the following:

To be eligible for appointment as school physician, the applicant must comply with the following requirements:

1. Be a citizen of the United States.
2. Be licensed to practice medicine in New Jersey.
3. Enroll in and regularly attend a course of instruction given by the State Department of Public Instruction.
4. Satisfactorily pass a written examination at the close of the above mentioned course.

In arriving at these steps, the following points were duly considered and eliminated for reason:

1. Age.
2. Residence in New Jersey.
3. Residence within school district.
4. Membership in county medical society

Of the recommended code, the first item, "citizenship", requires no interpretation, nor does the second "licensed to practice medicine within the state."

The third point "enrollment in a course of instruction" was favored over the proposal to require a stated number of graduate credits

subsequent to medical school, similar to the New York and Pennsylvania requirements. The arguments against the graduate credit in specified courses are these: the expense following upon medical school and internship and the usual lack of income at that stage; the inability of the beginning practitioner to foresee the need for graduate work; the distances to the graduate schools from a large part of New Jersey; the unfairness of asking a beginner to take the necessary time from his practice; and the limited scope of courses now available.

In favor of the recommended requirement, are these points: the state department of public instruction is legally empowered to conduct such courses, to give collegiate credit, and to grant degrees; the department can hold such courses at places convenient for the enrolled physicians, conducting as many as may be necessary and at any time of the year; the department can draw from the faculties of the several normal schools and teachers colleges under its jurisdiction; and, the course itself can be adapted to the needs of the schools; and it can embody the essentials of the many related courses offered separately by the universities.

The state course would effect a great saving of both time and money for the physician, because it can be moved to convenient points and held at hours least disrupting to the physician's practice. More important, it can deal specifically with the school health program, including at the same time the essence of public health, child psychology, mental hygiene, principles of education, school administration, and other topics contributing to the fundamental needs of a school physician. In such a course, it would be possible to call upon individuals for specific contributions in their respective fields such as, for example, members of the State Department of Health, or of the State Department of Institutions and Agencies, experienced school physicians, psychiatrists, tuberculosis specialists, and school administrators.

The committee respectfully submits the above plan for consideration.

Respectfully,

Allen G. Ireland, *Chairman*,
Donald B. Hull,
Grace M. Kahrs,
Dorothy Lottridge,
Joseph Schapiro.

February 18, 1935.

THE REPORT OF THE STATE MEDICAL ADVISORY COMMITTEE TO E. R. A.

By Spencer T. Snedecor, M.D., Hackensack, N. J.

By act of the House of Delegates in session June 14, 1934, this committee was authorized to ratify an agreement between the Medical Society of New Jersey and the New Jersey Emergency Relief Administration for the continuation of the mutual administration of medical relief on the same basis as the previous agreement. It was November before a formal ratification was obtained from the E. R. A. and then it was concurred in only until the expiration of the relief law on February 28, 1935. An interim agreement until the House of Delegates meets April 30 has been arranged.

The personnel of the committee was changed by President Ely to make a larger and more representative state unit composed of the chairmen of all the county committees, the Councilors and two or three others. From this group an executive committee was appointed consisting of seven men, designated because of their experience with the relief work and their easy access to Newark where it has been necessary to hold frequent meetings at the E. R. A. headquarters.

The wisdom of these organization changes has been quite apparent. The larger executive committee acting as the Medical Advisory Committee to the E. R. A. has felt itself more truly representative and able to make responsible decisions for the profession as they became necessary. Frequent meetings have been held by the executive committee, sometimes as often as once a week. Two general meetings of the full committee in Trenton have been held.

The essential problem of the year has been the continued development of medical organization in supervising the medical service and in obtaining better contact and coöperation between the county and local units.

THE MIDDLESEX PLAN

Two interesting variations of the general scheme are worthy of mention. Middlesex County, under the leadership of Dr. Fithian, has instituted a decided change which we shall briefly describe. Instead of the general procedure of a relief client applying to a case worker or relief office for a medical authorization, the patient goes directly to the doctor. The physician calls one of the six designated referee doctors in the county and requests an authorization for the call and as many additional calls as he feels necessary. The referee doctor may question the diagnosis and necessity for making the calls if he desires; and forthwith sends a memorandum to the E. R. A. to issue such an authorization to the doctor, if investigation proves the patient worthy of medical relief. Additional calls are issued in the same way. The six referee doctors in Middlesex County are named by the county society and are responsible to it. A thorough trial of this plan may show that it is an improvement worthy of wider adoption.

THE UNION COUNTY PLAN

In Union County better medical supervision has been secured through another method. Dr. Banker, acting as a member of the county medical committee, spends certain hours in the E. R. A. office checking and assisting in all medical relief work. For this service he is paid a small salary by the E. R. A.

The medical relief plan of the State Society is not in operation in Hudson County. Although numerous requests for the plan have come from individual doctors in that county, we have not felt that we should take any steps without a request from the county medical society as the representative unit.

MILEAGE

The justice of paying mileage to doctors making calls in the remote parts of rural counties was recognized. The committee recommended to the E. R. A. that a mileage rate of ten cents a mile outside a three-mile radius be tried out in Burlington County.

C. W. A.

The committee wishes to report that it has been unable to obtain any satisfaction from the United States Compensation Commission in regard to reduction in doctors' bills for Civil Works Administration cases. After much futile correspondence the Commission denied us a hearing but offered to send a representative to meet us. He has not appeared.

CHIROPRACTORS AND OSTEOPATHS

The chiropractors and osteopaths have been troublesome in their demands that the relief clients be given free choice to go to the cults for treatment. The E. R. A. Council, supported by opinions from its own counsel, Mr. John W. Griggs, and the counsel of the State Medical Society, Mr. Albert W. Wall, has held that it has full power to make medical policies; and its policy, based on economy and medical efficiency, is that a relief client shall go first to a general practitioner. Then if treatment by a specialist or limited practitioner is deemed necessary by him it may be authorized.

RULINGS

Two significant rulings have recently been passed by the committee: First, instead of making the $250.00 maximum ruling compulsory the committee recommends to each county committee that the maximum amount allowed to any physician be $250.00 per month and the county committee be given the right to approve bills exceeding that amount if they think they are fair to all concerned.

Second, in regard to part-time public physicians, the committee will consider for recommendation for inclusion on the E. R. A. approved list any physician other than full-time municipal county or state employee, if this recommendation has been approved by two-thirds of the members present at a meeting of a component society, providing that all members of the society have been notified of the proposed action.

In regard to the close contact and vital supervision of this work which it is necessary for the individual county committees to exercise, four phases are outstanding at present.

1. The M-30 forms upon which the doctors report each month the number of cases, diagnosis and calls to the county committee must be accurately and carefully checked in order to control improper authorizations.

2. Since under this plan the medical society pledges itself to prevent unnecessary hospitalization, the committee must take an active interest in the hospitalization of relief clients. Furthermore, it is advantageous to the profession that such cases as do not actually require hospitalization shall be treated at home. The question of elective operations, of prolonged hospitalization and questionable diagnosis on the hospital reports must be looked into.

3. The cost of medical supplies which includes drugs is seemingly very high. A study of the various items in this group is being made and will give us a more reliable index.

However, we do recognize that there is a problem in the control of drugs. Into this the pharmacist enters. A formulary for E. R. A. clients has been suggested. Your committee carefully considered it and decided that it was neither practical nor advisable. Our present belief is that the restriction to U. S. P. and N. F. prescriptions plus such few additions as we may designate is fundamentally sound. However, we accept the further responsibility that we will aid in setting up active committees from the pharmaceutical society in each county to check all drug bills and coöperating with them.

4. The county committee must be ever zealous to protect the interests of the physician and see that he receives fair play and square pay for the services which he renders to relief clients. Because of frequent changes in the personnel and the general emergent and transient nature of their work, the E. R. A. is by no means as efficient as we might wish for in issuing authorizations for medical services and in paying the doctor's bill promptly.

In summarizing, we may say that the year of continued coöperation with the E. R. A. has paid the physicians a fair return for the services rendered to the people on relief.

Statistically during the year ending October 13, 1934, $640,000 was paid to doctors (including modest sums to dentists and nursing services), $258,000 was paid for medical supplies and $807,000 to hospitals. We wish to emphasize that our relations with the E. R. A. have been very happy. Each problem has been met in a mutually coöperative spirit.

Also we wish to express our appreciation of the whole-hearted support of the members of the committee at large and the earnest and constant help of the Executive Committee.

Respectfully submitted,

Spencer T. Snedecor, *Chairman*,
E. Zeh Hawkes,
Christopher C. Beling,
George W. Fithian,
Charles H. Schlichter,
Byron G. Sherman,
Charles G. Kelley,
Aldrich C. Crowe,
James A. Fisher,
Frank G. Scammell,
Lancelot Ely.

REPORT OF THE CONCILORS OF THE FIVE COUNCILOR DISTRICTS

FIRST COUNCILOR DISTRICT

During the past year all the component societies were visited. Their activities have already been reported in the Journal. High standards of scientific work have been maintained. No matters of an ethical nature were brought to the attention of the Councilor.

A great deal of interest has been manifested in the economic phases of medical practice. Every Society has coöperated wholeheartedly with the State Society and the Emergency Relief Administration.

Essex, Union and Morris County Societies have numerous large, active committees which have been doing excellent work.

The Annual District Meeting will be held on April 11th at the Academy of Medicine of Northern New Jersey. The Essex County Medical Society has again generously placed its facilities at the disposal of the Councilor. At this meeting Dr. Francis H. Glazebrook, Medical Director of the New York Stock Exchange and a member of Morris County Society, will present for discussion a plan for the public distribution of medical services at reasonable rates. (March Jour., p. 148.)

With full appreciation of the necessity of leadership on the part of the profession for the provision of adequate medical care to all the people of the State, the societies of this District, keenly alive to their responsibilities, are endeavoring earnestly to coöperate with the State Society in its efforts to improve community health services through organized effort.

The Councilor of the First District takes this opportunity to express his thanks to the officers and members of the Component Societies for their kindly reception and coöperation.

Christopher C. Beling.

SECOND COUNCILOR DISTRICT

The Councilor of the Second District of The Medical Society of New Jersey has had no occasion for the exercise of censorial functions during the past year. He has coöperated with Dr. Beling, Chairman of the Judicial Council, and has kept in touch with the activities of the component societies of his district.

Charles B. Kelley.

THIRD COUNCILOR DISTRICT

The Third Councilor District of the Medical Society begs leave to report there have been a few minor disturbances, professional in nature, which have been agreeably settled between the various members. There is one case still pending to be taken up before the complete meeting of the Councilors, and I am hoping for an amicable disposition before the Annual Meeting.

FRANK G. SCAMMELL.

FOURTH COUNCILOR DISTRICT

Activities in the Fourth Councilor District have been intense during the past year, with considerable stress being laid to emergency relief problems and medical economics in general. It is most gratifying to report that the profession as a whole is wide awake to the necessity for concerted effort and is beginning to think as a group rather than individuals. No serious complaints have come to my attention, and to my knowledge no mal-practice suits are pending.

The Fourth Councilor District will hold its annual meeting at the Laurel in the Pines, Lakewood, N. J., on the evening of April 3rd. The evening will start off with a serious discussion of Medical Economics at 6 p. m., followed by a dinner and a floor show. It is hoped that the attendance will be large.

JAMES A. FISHER.

REPORT OF THE FIFTH COUNCILOR DISTRICT

The work done by the Councilor of the Fifth District has been one primarily concerned with the Emergency Relief Administration and Public Health Hour, both sponsored by the State Society.

Various meetings and conferences have been held at different parts of the district.

There are no malpractice suits in this district at the present time.

The Fifth Councilor District meeting will be held this year at Woodbury, New Jersey, April 18, 1935, under the auspices of the Gloucester County Medical Society. We have a very excellent program arranged, and from all indications we will have the largest attendance of any meeting of this type held in this district so far.

ALDRICH C. CROWE.

REPORT OF THE COMMITTEE ON THE CONTROL OF CANCER

By HENRY B. ORTON, M.D., Newark, N. J.

To the House of Delegates:

The Committee on the Control of Cancer of The Medical Society of New Jersey submits the following outline of "A Coöperative State Program of Cancer Control", under the auspices of the committee:

Objectives:

> "An enlightened lay group presenting itself either periodically or early, while the lesion is local, to a well-informed family physician who is able to entertain symptoms, who appreciates his limitations and who will refer his pay and indigent cases to a competent group" or individual "for diagnosis, prognosis and outline of treatment."—Ed. Jour. A. M. A., Jan. 5, 1935.

Agencies:

The State Medical Society,
The State Health Department,
The American Society for the Control of Cancer.

Executives:

The Chairman, Cancer Committee, State Medical Society,
The State Health Officer,
The State Chairman, American Society for the Control of Cancer.

(1) THE STATE CANCER COMMITTEE

The Cancer Committee of the State Medical Society should be more or less permanent. A minority of its membership may be appointed each year for a period of three to five years in order that the efficiency of the committee be not impaired.

The Medical Approach:

(a) Organize sub-cancer committees in County Medical Societies.

(b) Arrange cancer programs for County Medical Societies; at least one meeting each year.

(c) Arrange cancer symposia and clinical demonstrations on district and sectional bases through the active clinical groups and otherwise.

(d) Arrange cancer features for annual State Medical Society meeting, viz: special papers and exhibits.

(e) Arrange for publication of editorials and special articles on cancer in State Medical Journal; develop if possible a special department on cancer.

(f) Encourage post-graduate work among physicians, of questions on cancer in State Board Examinations, by making attendance of internes at cancer clinic sessions and conferences obligatory in institutions where clinics are in operation.

(g) Assemble educational material such as lantern slide collections, film strips, moving pictures, projectors, reprints, radio broadcasts and news releases and special publications for use in carrying out the above educational activities. Much of this material is available through the American Society for the Control of Cancer.

Clinical Facilities:

(a) Encourage organization of cancer clinics in approved general hospitals in accordance with the program of the American College of Surgeons. Literature, film strips, etc., pertaining to clinic organization are available through the A. S. C. C., a representative of which is available for assisting groups in organizing clinic activities. See publication "Organization of Service for the Diagnosis and Treatment of Cancer, a Minimum Standard", American College of Surgeons.

(b) Study state in reference to number and location of cancer clinics necessary to meet its clinical needs. Coördinate the trend toward clinic organization in keeping with this study.

(c) Encourage assignment of beds for cancer cases in general hospitals.

(d) Encourage development of facilities for hospitalization of incurable cancer cases.

(e) Encourage development of adequate pathological service for physicians and hospitals.

(f) Encourage and assist in organization of research activities.

(g) Encourage gifts of funds for research and development of clinical facilities. Assist in raising funds for employment of needed personnel and for purchase of physical equipment, radium, etc.

Miscellaneous:

(a) Develop and correlate the interest of the following professional groups by educational work so they may become qualified to assume their proper place in the program.

(1) The dental profession. Establish contact with the State Dental Association and encourage educational activities among the dental groups similar to that among the medical groups, this directed essentially at cancer of the buccal cavity.

(2) The public health groups (see State Health Officer).

(3) The nursing groups. Establish contact with the State Nurses Association and other nursing groups for educational purposes. Included in the educational work for nurses may be the following:

One lecture on cancer annually at the beginning of the senior year in each training school.

Emphasis on cancer in nurses' training courses.

Questions on cancer in examinations for nursing diplomas and state license.

Distribution of Handbook for Nurses, published by the American Society for the Control of Cancer, to each senior nurse in training schools.

Publication of articles on cancer in state nursing publications.

(4) The Social Service groups. Establish contact with those groups dealing with the social problems arising through disease particularly with reference to cancer in its relation to the general problem of chronic illness.

(b) Organize a speakers' bureau from the various cancer committees with services of lecturers and talks before lay and professional groups and radio broadcasts.

(c) Develop a continuing program of lay education in coöperation with the State Health Department and State Chairman of the American Society for the Control of Cancer.

(2) State Health Officer:

(a) Stimulate interest and activity in cancer control by conferences of health officials.

(b) Organize meetings for purposes of cancer education among public health, visiting and industrial nursing groups and joint meetings of these and related social service groups.

(c) Publish articles on cancer in state, county and city health bulletins which reach the professional and lay groups.

(d) Organize the State Division of Vital Statistics as a clearing house for data on cancer mortality and morbidity with services to cancer committees, health officials and physicians. Broaden its statistical studies on cancer and publish data in the State Health Bulletin. Stress the importance of accurate registration of causes of death.

(e) Publish bulletins and pamphlets on cancer, and include these in the list of educational material for distribution.

(f) Correlate subject of cancer control in the general health program under sponsorship of State Health Associations.

(g) In coöperation with the State and County Medical Society Cancer Committee and the State Chairman of the American Society for the Control of Cancer engage actively in lay education through the division of public health education and city and county or district health units by means of lectures and films, pamphlets and bulletins, news releases and radio broadcasts.

(3) State Chairman:

(a) Coöperate with the Cancer Committee of the State Medical Society, and coördinate the facilities, policies and program of the National Society in the organization of the state program.

(b) Participate in lay and professional educational activities through cancer meetings for the professional groups, lectures and talks to women's groups, civic clubs, industrial groups, teaching, college and high school groups and others by:

(1) Supplying exhibit material, both lay and professional.

(2) Supplying standard news releases and radio broadcasts.

(3) Supplying film strips and moving picture films and projectors.

(4) Distribution of literature and medical reprints and abstracts.

(c) Make available the services of the field staff of the National Society in organizing and conducting the state program, for making special state studies, in developing meetings, in assisting in clinic organzation and by acting as an information bureau through the central office and in other ways.

The Department of Institutions and Agencies of the State of New Jersey has issued "Suggestions for a Cancer Control Program in New Jersey", which lists the existing public cancer clinics and laboratories and suggests additional public measures, many of which are to be under the control of the state and are not acceptable to the Committee of the Medical Society.

Respectfully submitted,

HENRY B. ORTON, *Chairman,*
ROBERT HALBACH,
PHILIP MARVEL,
GEORGE SOMMER,
HARRISON B. WILSON,
HARRISON S. MARTLAND,
JOHN W. GRAY,
EDWARD J. ILL.

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

By CHRISTOPHER C. BELING, M.D., Newark, N. J.

To the House of Delegates:

The Committee on Medical Defense has met at frequent intervals during the past year to consider several important cases that came up for consideration.

In one case a doctor desired to have a change of counsel because he was fearful that he would lose his case on a retrial, if it was tried along the former lines. In this case the Company coöperated to the extent of agreeing to substitute counsel. A mistrial was declared and upon the retrial the doctor will be granted a substitution of counsel.

There were 68 new cases of alleged malpractice reported. There were 22 old cases still pending. Approximately 2,250 doctors have taken out policies. This is an increase of nearly 300. This figure might be changed after the annual list of members is published.

The committee draws attention to a very important and beneficial change in the contract which the company suggested and carried out

by mutual consent. Heretofore the policy would become void in the event the name of the physician insured did not appear on the official list published by the Society. Provision has now been made that the termination of the contract would not become effective until sixty days following the publication of the official list, but not later however, than May first of any year.

Reviewing the causes ascribed for the bringing of suits, 10 were brought as the result of death of the patient. Two of the death cases followed tonsillectomy. There is a tendency to consider the operation of tonsillectomy as a minor surgical proceedure, but these two cases show that serious consequences can follow such an operation. The next in importance were burns resulting from the application of diathermy and other electrical modalities.

There is no doubt that the public expects a great deal of the doctors nowadays because in several cases, a wrong diagnosis, negligence to treat properly, and failure to cure, figure largely as causes for suits.

A further detailed report will be submitted at the annual meeting. The committee has no recommendations to make at the present time. The committee is hopeful that the present schedule of rates will be maintained for the ensuing year, even though there has been an increased number of claims and more expenditure during the past year.

Christopher C. Beling, *Chairman*,
William J. Arlitz,
Edgar A. Ill,
John C. McCoy,
Erwin Reissman.

NINTH ANNUAL REPORT OF THE COMMITTEE ON INSURANCE

By Frank W. Pinneo, M.D., Newark, N. J.

To the House of Delegates:

The Committee is pleased to submit a report for the past year, which, however, is for but a little more than ten months, because of the early date of this annual meeting. The year has been marked by a great increase in the service rendered to members, their universal satisfaction as expressed in letters of appreciation received, and the marked increase in number of policy-holders notably so in Automobile Insurance, and in the amount and number of claims paid.

ACCIDENT AND HEALTH INSURANCE

The group policy is the original one negotiated by us nine years ago, and is still in force without change, except as initiated and negotiated by us, always to improve the contract in coverage or the easing of terms for premium payment. These changes have been:

(1) Broadening the interpretation of "total disability" as not limited to "house-confining" and extending the time for disability from sickness, to six weeks instead of four.

(2) Offering the same policy for half the amount if chosen.

(3) Offering sub-divided payments of premium, annually, semi-annually, or even monthly. Travel by airplane on scheduled routes operated by licensed aviators, is included without additional premium.

The claim of the company that the loss ratio in the third age-group (members over 60) demands higher premium, has been met by the statement that the policy was intended to cover all ages of members and therefore the loss ratio must include that of all ages. The classification in three groups, by ages, makes an admirable adaptation of premium to respective ages so that young members do not bear the burden of losses from the older. The agreement reached was that the application by the older members shall be somewhat more extended than the brief statement hitherto on health, this to obviate losses from *existing* diseases which of course, no company will cover.

AUTOMOBILE INSURANCE

The year has been characterized by great increase in number of policy-holders, and also in very marked benefits to such as have had claims for accidents. A very unique advantage in our policy, and not obtaining in any others known, is the service of the agency to handle, in the interest of our policy-holder, his claim against the other party in an accident, this agreement covering all the expenses of investigation and adjustment, even legal advice and law-suit, if necessary, all without increased premium. This is a matter of service by the agency and, alone, is worthy of consideration.

In conclusion, we call your attention to the

exceptional liberality of negotiation by both companies in freedom from technicalities in the settlement of claims, even when members have flagrantly violated their own obligations in the contract, such as failure to report illness or accident promptly. This of course cannot be always guaranteed, for a company may tire of liberal treatment if members abuse it by failure on their own part. The communications by the agencies and the information given in County Society Bulletins are too often ignored by the members, so that they miss information and services which their society dues include. Why not use what you pay for?

(Signed)

Frank W. Pinneo, *Chairman*
Barclay S. Fuhrman,
Wayne W. Hall,
Edmund N. Huff,
A. Dunbar Hutchinson,
Warren D. Robbins,
Chester I. Ulmer.
Committee.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By John F. Hagerty, M.D., Newark, N. J.

To the House of Delegates:

The reports of the Delegates to the American Medical Association are of immediate interest, and have been published in our Journal as soon as possible after the meeting.

The report of the annual meeting of the A. M. A. held in Cleveland on June 11-15, 1934, was printed in The Journal of July 1934, page 427. This report is of special importance, for it includes the ten principles which the A. M. A. adopted regarding health insurance.

A special meeting of the House of Delegates of the A. M. A. was held on February 15-17, 1935, and was reported on page 157 of the March Journal. This report included the full report of the Reference Committee regarding the attitude of the medical profession toward the proposals of the Federal Committee on Economic Security for giving medical service to persons having low financial means.

These two published reports are submitted as the report of the Delegates to the American Medical Association during the past year.

Attention is called to the fact that this year's meeting of the A. M. A. will be held in our own Atlantic City on June 10-14.

Respectfully submitted,

John F. Hagerty, *Chairman.*
A. Haines Lippincott,
Walt P. Conaway,
E. R. Mulford.

REPORT OF COMMITTEE ON SCIENTIFIC WORK

By Ralph K. Hollingshed, M.D., Westville, N. J.

Following a custom that was established some years ago, the Officers of the State Society, the Committee on Program and Arrangements, the Committee on Scientific Work, and the Chairmen of the several Scientific Sections met in joint session in November and discussed plans for the scientific program of the Annual Meeting.

It was decided to devote Wednesday, May 1st, to a session on medicine, and a session on surgery. The program of each session is to be limited to four papers.

Thursday, May 2nd, will be devoted to the section meetings. Each section is to have a morning, and an afternoon meeting.

The Chairman of the Committee on Scientific Work, with the aid of the other members of the Committee, was authorized to arrange the program for the general sessions; and the chairman of each section to arrange the program for his own section.

The thought of the committee in planning for the general sessions has been to have several speakers of national reputation placed throughout the program in order to attract and hold the members to the meetings.

In addition to this it has been the desire of the committee to have, as nearly as possible, each section of the State represented in the program.

As far as possible the selection of speakers from our own society has been made from those who have expressed a desire to present papers. It has not been expedient to place all those on the program who have signified their willingness to appear before the society.

It is the feeling of the committee that section 3 of Chapter 5 of the By-Laws (time of the election of officers) should be changed so that the entire day may be devoted to scientific papers.

There is always the possibility of a repetition of the delay which followed the report of the Nominating Committee last year. If this should occur again, it would seriously interfere with the scientific program, just as it did at that time.

The committee is of the opinion that the action of the Board of Trustees on December 16, 1934, in creating a section on general surgery is at this time a mistake, and would recommend that this action be rescinded. Practically all that there is left now for the general sessions is general surgery and internal medicine. If general surgery is taken from the general sessions, perhaps it might be well to make a section of internal medicine. Then there will be no need for the general sessions, for everything will be taken care of in section meetings. If this is done, we feel that a section on medical economics should be considered.

(Signed)

Ralph K. Hollinshed, *Chairman.*
Clarence C. Andrews,
Louis C. Lange,
Committee.

REPORT OF THE COMMITTEE ON ARRANGEMENTS

By W. J. Carrington, M.D., Atlantic City, N. J.

Plans for the One Hundred Sixty-ninth Annual Meeting of The Medical Society of New Jersey are nearing completion.

The sessions will be held in Haddon Hall, Atlantic City, April 30, May 1 and 2. The Board of Trustees will meet on Monday evening, April 29. The House of Delegates will meet Tuesday morning at 10 to 12:30 and again at 2:30 on Tuesday, April 30. The Reference Committees will meet Tuesday at 8:30. Scientific sessions will be held on Wednesday from 9:30 to 12:30 and from 2:30 to 4:30.

On Wednesday there will be a banquet for the members and their ladies at which the President and the President-Elect will make addresses.

Thursday will be devoted to section work and on Thursday from 4:30 to 6 there will be the final meeting of the House of Delegates.

Respectfully submitted,

Wm. J. Carrington, *Chairman.*
John W. Gray,
I. B. Morrison,
Lancelot Ely.

REPORT OF THE COMMITTEE ON SCIENTIFIC EXHIBITS

By John W. Gray, M.D., Newark, N. J.

To the House of Delegates:

The Scientific Exhibits have become an important part of the scientific program of the Annual Meeting. They are just a part of the big show for some, but a fountain of knowledge for others. Exhibitors who spend months in preparation often wonder if it is worth the effort. The committee is convinced, however, that interest is not lacking, and that every exhibit will teach a valuable lesson if the exhibitor is present to see that it is taught. A representative should not only be continuously present at each booth, but there should also be a specified time when the author might be consulted. The committee has decided that from 11 to 1 o'clock each day would be a favorable time for such consultations.

This year several applicants desired to show x-ray films in connection with their general exhibits. Heretofore, it has been necessary on

such occasions to insist upon paper prints being made; but such prints are never as satisfactory as films shown by transmitted light. We would suggest that a few smaller illuminating units be constructed next year so that they may be worked in with the general units now available.

The committee was highly pleased with the Journal's coöperation in its preliminary announcement, which definitely brought the subject to the attention of all members of the State Society and gave them an early opportunity to make applications.

Respectfully submitted,

John W. Gray, *Chairman*,
Harrison S. Martland,
Asher Yaguda,
H. R. Casilli,
Robert A. Kilduffe,
Wallace W. Mayer.

COMMITTEE ON ART AND HOBBY EXHIBIT

By William K. Campbell, M.D., Long Branch, N. J.

To the House of Delegates:

The interest shown in the two art and hobby exhibits that have been held at the Annual Meeting has encouraged the committee to conduct another this year. That of 1933 was described in the Transactions of that year, page 54, when twenty-one physicians and eleven members of their families took part.

In 1934, twelve physicians and nine members of their families showed specimens of art and collections, which were described on page 359 of the June Journal.

The committee in charge of the exhibit was continued, to coöperate with the Art and Hobby Exhibit of the Woman's Auxiliary. The combined committees met on January 29, 1935, and planned a third exhibit as described in The Journal of February 1935, page 102. It was decided that the Woman's Auxiliary was peculiarly well fitted to promote the exhibit. It was therefore planned that the exhibit room should also be the headquarters of the Woman's Organization. The room will be fitted with easy chairs, an dtea will be served each afternoon. This arrangement will insure the presence of members who will be prepared to explain the specimens and to make the exhibit a social affair and a center of special attraction.

Mrs. H. D. Corbusier, 612 Park Avenue, Plainfield, was appointed by Mrs. Casselman, President of the Auxiliary, as chairman in charge of the exhibits, and applications for space should be made to her. No entrance fee will be charged. No prizes are offered, for it is expected that the pleasure and enlightenment of the visitors will be the reward of exhibitors.

Respectfully submitted,

William K. Campbell,
March 18, 1935 *Chairman.*

REPORT OF THE STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

By James J. McGuire, M.D., F.A.C.P., Secretary, Trenton, N. J.

To the House of Delegates:

LICENSES

Since the last report to the Medical Society of New Jersey, the State Board of Medical Examiners of New Jersey has issued 335 certificates of license, 250 to physicians and surgeons who passed the examinations of the Board, and 85 to physicians and surgeons by endorsement of certificates of license from other states. Twenty-three osteopaths have been licensed by examination, and 7 by endorsement. Seventeen chiropodists, 3 midwives, and 2 chiropractors have passed the examinations and received their certificates of license. The two chiropractors licensed qualified for the examinaton under one of the exemptions contained in section 11 of the supplement to the medical law.

REVOCATIONS

The certificates of license of 4 physicians and 1 midwife have been revoked. The revocation in each case was for conviction of a crime involving moral turpitude. Revocation proceedings have been started against four

other physicians. The complaint in each case is the practice of criminal abortion. Three of the cases are to be decded on direct testimony to be produced before the Board, the other case is based on a record of conviction in a criminal court.

COURT DECISIONS

The cases of the Board vs. Mary Miller and Nancy Kehoe were tried jointly before the Paterson District Court and a judgment entered in each case for the Board. The defendants obtained a writ of certiorari and after reviewing the case the Supreme Court held:

> "Mary Miller has a license to practice chiropractic only. The proofs show that Mrs. Miller had an office and treating rooms at 327 Park Avenue, Paterson, with the sign 'Dr. Mary Miller' on the window and the words 'Dr. Miller' on the door mat; that she diagnosed the the ailments of the witnesses and prescribed a diet of food and soda as a medicine, and administered electric treatments, which treatments were also given by Nancy Kehoe. Some of the treatments were for a fibroid tumor as diagnosed by Mrs. Miller, in which she changed the dressings; one for cancer, one for gall-bladder and bronchial trouble. In one instance at least she directed the administration of opiates at the direction of a physician she called on the telephone. In addition to the foregoing she advertised herself as Dr. Miller under the classified list of physicians in the city directory.
>
> It is needless to say that under the authority of numerous cases of which it is only necessary to cite that of the State Board vs. Livesey, 140 Atl. 444, affirmed 105 N. J. L., 255, this constituted the practice of medicine without a license."

The unconstitutionality of the Medical Act was also raised and the Supreme Court said:

> "The suggested unconstitutionality of the general act is not argued and perhaps wisely in view of numerous cases in this Court and the Court of Errors and Appeals to the contrary."

The Supreme Court affirmed the judgments entered by the trial court. The defendants then appealed to the Court of Errors and Appeals, and the judgment of the Supreme Court was affirmed.

The case of the Board vs. Louis Adler was tried before the First District Court of Newark and a judgment entered for the Board. Adler, who had been previously convicted of practicing medicine, has a remedy which he claims will cure cancer, but the Board produced evidence to prove that several persons who had taken his remedy did not recover.

The Supreme Court said:

> "Adler had an office in which he apparently received patients. He was not licensed to practice nor did he have a doctor's sign displayed or call himself 'doctor', but he undoubtedly, as testified by the witnesses called by the board, diagnosed the physical ailments of these witnesses, prescribed medicines and charged therefor sums clearly indicating that it was for the advice as well as for the medicine. This, under all our cases, established the practice of medicine within the meaning of the act under such cases as State Board vs. Buettel, 102 N. J. L. 74, and numerous other decisions anterior and subsequent thereto."

PROSECUTIONS

Among the most difficult cases to investigate are the Medical Advertising Offices. Three of these offices were investigated during the past year. The Board found that patients were induced to take treatments through advertising *broadcasts over the radio*. They found that one woman died as the result of an infection following an injection for varicose veins, and another patient nearly lost her life for the same reason. They also found that many people paid large sums of money for treatments from which they received no benefit; also that the treatments were given by lay managers of the offices who, as far as the Board knows, have had no medical training.

Full information in regard to the character of work being done by the medical advertising offices using one of the radio stations, and the complaints being received by the Board, were given to the manager of the station, but the broadcasts were not discontinued.

The Board then arrested the lay managers of the offices for practicing medicine without a license. In addition, it presented the evidence it had obtained to the Federal Communications Commission, which was considering a request for renewal of its license from

one of the radio stations broadcasting these programs.

Another important matter which was brought to the attention of the Board during the past year was the work being done by one of the Visiting Nurses' Associations in New Jersey. Complaint was made to the effect that nurses connected with the organization made one, and sometimes two calls on patients without a physician's order. The complaint was found to be true, and the matter will, no doubt, be satisfactorily adjusted at conferences to be held with all interested parties.

Court Cases

Convicted, pleaded guilty or settled	20
Listed in Court ready for trial	20

Decisions of Higher Courts

Won by Board—writ of certiorari allowed—judgment affirmed by Supreme Court—appeal by defendant to Court of Errors and Appeals—Supreme Court sustained	2
Won by Board—Appeal by defendant to Supreme Court—judgment affirmed	1

Hearings for Revocation of Licenses

Medical:	
Certificates of License revoked	4
Cases pending	6
Midwifery:	
Certificate of License revoked	1

Miscellaneous Investigations

Visiting Nurses' Association	1
The Board of Regents of the State Board of Naturopathic Examiners of New Jersey	1
Radio Broadcasts of Medical Advertising Office	1

Analysis of Inspections and Investigations

Total number of Investigations and Inspections made	149
Total number of Visits and Treaments received in making the investigations and inspections	850
Average number of Visits per Investigation	5.7

Type of Case Investigated

Druggists practicing medicine	23
Prescribing herbs and drugs	21
Medical doctors	12
Unlicensed chiropractors	6
Chiropractors exceeding license	4
Osteopaths exceeding license	8
Chiropodists, unlicensed and exceeding license	4
Electro-therapy	3
Naturopaths	6
Midwives, unlicensed and exceeding license	2
Miscellaneous	42
Medical—Revocation	4
Midwifery—Revocation	1
Colonic therapy	5
Physiotherapists	4
Psychoanalysts	1
Radio Broadcasting	1
Schools operating without license	2
	149

THE WOMAN'S AUXILIARY

By MRS. A. J. CASSELMAN, Camden, N. J.

To the House of Delegates:

The Woman's Auxiliary to The Medical Society of New Jersey has received the formal recognition of the parent society during the past year by the appointment of an Advisory Committee to the Auxiliary, consisting of Drs. Dan S. Renner, W. K. Campbell and E. W. Sprague. The reports given at our annual meeting on June 6, 1934, revealed a multiplicity of projects conducted by the local groups, but without a uniform definiteness of purpose or a central leadership to achieve uniform objectives throughout the State. Consultations of the Auxiliary leaders with the officers of the State Society resulted in the discovery of certain State Medical activities in which the Auxiliary could supply an essential link of service which was then missing. The Auxiliary therefore offered to act as a liaison group between the medical societies and the lay health organizations in promoting popular health lectures. The plans and objectives were set forth in editorial comments in several issues of The Journal of last Summer and Fall (August, p. 441; September, p. 551; and October, p. 612).

The project was discussed in the organization meeting of the Committee on October 8, and President Ely announced that the State Society had appointed an Advisory Committee in order to assist the Auxiliaries in their plans. With this recognition and encouragement the Auxiliary has developed definite activities which are extensions of those already conducted by the parent medical societies.

THE SPEAKERS' BUREAU

The new project of the Auxiliary has centered on what we have termed "The Speakers' Bureau". The State Speakers' Bureau is only partly organized. This project, like any other new line of work, has been slow in starting, but it has been well received. It is now gaining impetus, and is proving its essential value in providing a close contact of the medical profession with lay health organizations.

The State Board of the Auxiliary has made up and approved of a tentative list of speakers composed of physicians, psychologists, and psychiatrists. There is difficulty in securing physician speakers who will travel any place in the State without renumeration; therefore, it has been necessary to draw our list mostly from the employees of state institutions and from the State and local Health Departments. These men and women are accustomed to speaking and travelling and will go any place in the State. The County Speakers' Bureau is functioning in nine of our fourteen organized counties. We have no way of checking how many talks have been given. We can only report progress. It is to be understood that it will take several years to have the Speakers' Bureau functioning properly.

The idea of the Speakers' Bureau primarily was to place the physician and the County Medical Society before the public, and to give to the lay organizations authentic health information. Public speaking is an accomplishment and all are not adapted to the calling. Neither are all qualified to speak. Would it not be well for medical societies and medical auxiliaries to have on their programs occasionally a psychologist or a psychiatrist, who, I am sure, could give to them a wealth of knowledge which the speakers in the audience could use in their own addresses to the public?

What have you who read this article done to promote this publicity scheme? Are you cooperating to the best of your ability? Have you any constructive criticism to offer?

We know some physicians do not want their names used in connection with the Speakers' Bureau. This publicity we feel is necessary, because organizations like to publish the names of their speakers and their subjects. We believe it is to our advantage to have physicians give these talks, rather than the misinformed speakers for advertising concerns.

MEETINGS OF THE AUXILIARY

Our State Auxiliary meetings have been well attended and our women who belong to the Auxiliary are interested.

The counties which are organized are holding regular meetings and doing good work. Many meet at the same time the medical societies do. We have been interested in visiting the County Auxiliaries. There are many obstacles to overcome. Are we working for the good of the organization, or our own personal gains? We feel the physician is facing a crisis. We all have one goal to seek, that of saving our husband's profession and preventing the loss of scientific medicine to the public.

CHARITABLE PROJECTS

The Auxiliaries seem to be charitably minded. One is contributing a scholarship for a nurse's training course. Another is assisting financially indigent physicians. Another county has in mind a convalescent physicians' home. One county is giving the Journal, Hygeia, to schools and libraries. Practically all our counties contributed to a foundation for research on feeblemindedness at the Vineland Training School. All have answered that this was a worthwhile project, and that they were glad to contribute to it. Some counties are sponsoring radio addresses by the physicians.

One county is holding a large card party yearly and most of the receipts go to the County Tuberculosis Association. There is no reason for the Auxiliaries being charitable organizations, but as long as their charities lean toward health and medical projects, there will be no objection.

PUBLIC RELATIONS

Another important project is the Public Relations meetings sponsored by the County Auxiliaries. To these meetings are invited all the lay organizations having health programs. An outstanding physician who has made notable contributions in research in the field of medicine or some one who is a true specialist talks to these groups. These public relations meetings are most important. They show these lay groups that the physician has years of experience and scientific research back of him—that he has something of value to give to the public. At these meetings the lay group is told that the physicians from our County Medical Societies will speak to their organizations if they so desire. The County Medical Societies have a great opportunity to place before the public one of the most outstanding educational programs they have ever undertaken, through the Speakers' Bureau, the Woman's Auxiliary to be the liaison group. We can accomplish much if we have the wholehearted support and interest of the Medical Society.

The Medical Societies must recognize that

through the Woman's Auxiliary they have their strongest ally with the public. With a member on every public welfare or public health committee in all women's clubs and associations, the Medical Societies and Auxiliaries can absolutely control the health programs of these organizations.

RECOGNITION

The Woman's Auxiliary is the active partner with the Medical Society in the project of the Speakers' Bureau. We suggest that the House of Delegates approve the principles of action under which the Auxiliary is conducting its work along the lines of publicity and public relations in coöperation with the medical societies.

The Woman's Auxiliary must have more support from the County Medical Societies. There are 3000 physicians who are members of the State Medical Society, and only 675 members of our Auxiliary. Every man who belongs to his county medical society should see that his wife, his sister and his mother are members of the Woman's Auxiliary and take an active part in civic affairs.

I close this report with a great deal of concern. Surely, our physicians are not blinded to smug complacency; surely they realize their field is being invaded. They need the Woman's Auxiliary more than ever before. We must be given something definite to do, and we cannot be too over-organized.

As an example of worth-while accomplishments of a County Auxiliary we are adding the following report of the Essex County Auxiliary written by its President, Mrs. Don A. Epler:

The Public Health Committee has been requested by the Public Health Committee of the Essex County Medical Society to assist it in furthering the accomplishments of public health work by the doctors.

The Past Presidents were appointed as a nucleus of a large committee to visit physicians personally and inform them of the wishes of the society.

The committee of twenty-five members from the Auxiliary visited a group of 729 doctors who had agreed to do the work of immunizing the preschool child. The list was divided among the members of the committee according to districts. The work partook of the nature of a drive, five weeks being the limit of time allowed. To ascertain the most popular Health Hour a double postal card was sent to each doctor giving a choice of three days and three hours. Over four hundred doctors responded to the postal card. Thursday at 1 p. m. was the hour chosen by the majority of doctors.

The committee was instructed concerning details of the plan of the Medical Society, and the outline of the work was planned. Each doctor was offered the *Health Hour Card* chosen by the majority; and if not convenient, a special card was made with his chosen day and hour.

An ethical letter was drawn up in card form for the doctor to send to his patients, and orders were taken for as many as he wanted. From 12 to 250 copies were supplied to each individual doctor. Some physicians mailed them out, while others left them in the waiting room for their patients to take. Between six and seven thousand cards were distributed among the profession.

A sample of a letter signed by the President of the Society, for distribution to the public by the health agencies, was left with the doctor for his information.

Out-dated toxoid and toxin-antitoxin was collected by the committee, and also reports of the children immunized which had not been reported to the Board of Health, and the importance of sending in these reports was stressed.

Packets were mailed with a letter of information to the doctors who were too far distant to be reached personally. Weekly reports from the members of the committee were made obligatory so that health cards and ethical letters could be sent out. Coöperation from the doctors was very encouraging. All comments by the doctors were reported to the Chairman of the Essex County Medical Society at the final meeting, March 13, 1935, at the Academy of Medicine.

Respectfully submitted,

ZULA BOYD CASSELMAN, *President,*
Woman's Auxiliary to the Medical Society
of New Jersey

March 25, 1935

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

By DAN S. RENNER, M.D., Skillman, N. J.

To the House of Delegates:

This has been a year of planning by the Woman's Auxiliary, and the Advisory Committee in order to discover a project which is already being undertaken by the Medical Society and in which the Auxiliary might be of essential service to the parent society, Medical publicity, and making contacts with lay health organizations seemed to be two fields in which the Auxiliary could act with satisfaction.

The new project of the Auxiliary has been

promoted in a tentative way. The Auxiliary leaders have made contacts with a few County Medical Societies, and have demonstrated the practicability of the Speakers' Bureau. The Advisory Committee has given advice regarding the choice of physicians as speakers before lay organizations.

The Advisory Committee has also given advice on founding a convalescent home for doctors, and on the organization of new auxiliaries.

Respectfully Submitted,
DAN S. RENNER, Chairman
WILLIAM K. CAMPBELL,
EDWARD W. SPRAGUE.

March 25, 1935

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

President Ely has appointed the following *Reference Committees* on the Annual Report, in accordance with the By-Laws, Chapter VIII, Section 14:

Committee A to consider:

The report of the President
The addresses of the President and the President-Elect
The report of the Executive Secretary
The report of the Board of Trustees
The report of the Secretary

EDWARD W. SPRAGUE, *Chairman*
MILLARD F. SEWALL — E. G. HERBENER
I. F. FROST — F. H. MORRISON

Committee B to consider the reports of:

The Publication Committee
The Committee on the Physicians' Lien Law
The Finance and Budget Committee
The Treasurer
The Insurance Committee
The Committee on Constitution and By-Laws

CHESTER I. ULMER, *Chairman*
R. E. SCHALL — FREDERICK P. WILBUR
JOSEPH W. HURFF — BARCLAY S. FUHRMAN

Committee C to consider the reports of:

The Committee on Program and Arrangements
The Committee on Scientific Work
The Committee on Scientific Exhibits
The Committee on Art and Hobby
The Delegates to the A. M. A.

EDGAR A. ILL, *Chairman*
GEORGE T. TRACY — JOHN E. MAHER
GEORGE F. DANDOIS — ALBERT J. WARD

Committee D to consider the reports of:

The Committee on Public Health
The Committee on Hospitals and Medical Education
The Medical Advisory Committee to the State E. R. A.
The Committee on Maternal Welfare
The Board of Medical Examiners

A. A. LAWTON, *Chairman*
DAVID W. SCANLAN — E. E. DOWNS
H. D. CORBUSIER — LOUIS A. PYLE

Committee E to consider the reports of:N

The Welfare Committee, and its Sub-Committees on:

Legislation
Medical Practice
Uniform Medical Practice Act
Workmen's Compensation

WILLIAM H. ARESON, *Chairman*
ELTON S. CORSON — DAVID B. ALLMAN
ARCANGELO LIVA — ROBERT E. WATKINS

Committee F to consider the reports of:

The Advisory Committee to the Woman's Auxiliary
The Committee on Cancer
The Committee on Nursing and Nursing Education
The Committee on Honorary Membership
The Committee on Medical Defense

WM. F. COSTELLO, *Chairman*
WM. F. SKINNER — B. T. D. SCHWARZ
SAMUEL SICA — WM. T. HILLIARD

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COMMERCIAL EXHIBITORS

The commercial exhibits at the Annual Meeting will be of unusual size and interest and will return to the Society a substantial profit. Following the example of the A. M. A. and some of the other State Societies, each exhibitor is given a write-up in the Journal.

The Kalak Water Co., Inc., 6 Church Street, New York, will occupy booth No. 5 and invites physicians to visit the booth and learn how delicious and refreshing Kalak is when properly served.

Obviously, the greatest use for Kalak Water is for routine use in the home when an alkaline water is indicated. It is generally recognized by physicians that the majority of people, and particularly those of sedentary haits, do not drink sufficient water, both for its value as a food and as an eliminant. Kalak solves this problem, for it combines purity and palatability.

Nestle's Milk Products, Inc., 155 East 44th Street, New York, will exhibit *lactogen*, *lylac*, and *Nestle's food* in booth 3. A feature of this exhibit is an attractive new book on "Infant Nutrition", a copy of which will be available to every interested physician who visits the Nestle Booth.

Horlick's Malted Milk Corporation, in booth No. 21, will explain the special uses of *Horlick's Malted Milk*, in natural and chocolate flavors, as a food of remarkably nutritive and digestible qualities, both in sickness and in health. Samples of *Horlick's Malted Milk Tablets* will be distributed as a reminder of their usefulness as a pleasing variant in the liquid diet, and as a beneficial confection for children.

The National Casualty Company, Jersey City, will demonstrate the group accident and sickness insurance policy that was designed especially for the members of The Medical Society of New Jersey; and was described on page 38 of the Journal of January 1935.

The broad coverage of the policy, the unequalled low rates of premium, the substantial character of the company, the agreeable manner of the manager and agency in dealing with claimants, and finally, the unique advantage of the State Society as your intermediary in the adjustment of claims—

are among the notable reasons for your carrying this policy.

Stop at booth 6 and get full particulars.

The H. G. Fischer & Company, 2323 Wabansia Avenue, Chicago, Illinois, will exhibit in booth 19, and will include its latest models of shockproof x-ray equipment, short wave high frequency apparatus, diathermy apparatus, accessories and technics. Visitors at the conference are invited to see these various models demonstrated. From the point of view of quality in materials and construction, actual performance, durability and dependability under hard usage, and low investment, the *Fisher* equipment is unexcelled.

Blair & Curtis, Inc., 100 Fifth Avenue, New York City, will demonstrate at booth 8 its important *Powdex Insufflator* and *Powdex Cartridges*, a standard dry treatment for *Trichomonas Vaginalis Vaginitis*. Other exhibits include their widely used *"VG" Powder Applicator and Cartridges;* original *Ramses Vaginal Diaphragm* with eleven new Half-Sizes; and their standard *Jellies, Gelakta* (Cooper) *and Gelaquin*.

The United States Fidelity and Guaranty Company, 11 Commerce Street, Newark, N. J., will occupy booth 31, and will demonstrate the *Professional Liability Insurance Policy* offered to members of The Medical Society of New Jersey with the approval of the Society.

This policy is the lowest in cost and highest in protection to Society members.

Faulhaber & Heard, Inc., will represent the Company at the exhibit.

E. R. Squibb & Sons, 745 Fifth Avenue, New York, will feature several new products recently made available, including physiologically standardized *Anterior Pituitary Extract* and a new and economical *Vitamin A and D* preparation. Other Squibb vitamin, endocrine, biological and arsenical preparations will be on display, and competent attendants will be present to discuss these and other Squibb products.

Petrolagar Laboratories, 8134 McCormick Boulevard, Chicago, Illinois, booth 25, will exhibit its five types of *Petrolagar* now available for the specialized treatment of constipation.

Each type serves a special purpose and enables the physician to fit the treatment to the particular need of the patient.

Samples of each of these five types will be given.

The Mennen Company, Newark, N. J., will again exhibit its two baby preparations—*Mennen Antiseptic Oil* and *Mennen Antiseptic Borated Powder*.

Last year the Mennen booth was one of the most popular at the convention and great interest in these two Mennen preparations was shown by those attending.

The Mennen Company not only will also distribute trial sizes of its popular line of shaving and after-shave preparations.

The Coward Shoe, 270 Greenwich Street, New York City, will display many interesting plaster casts of deformed feet at booth 7.

Motion pictures will be used to show the foot in action and its requirements for walking; and also how shoes can be intelligently applied for absolute comfort.

Over a 70-year period Coward has dealt with practically every form of foot disorder. The result is shown in 79 different lasts for as many differently shaped feet.

The Radium Emanation Corporation, Graybar Building, Grand Central Terminal, New York City, will exhibit applicators used in modern radium therapy, including removable and permanent *radon seeds* of the composite type with radon under leakproof glass seal. It will also exhibit patented loading slot instruments for implanting seeds; uterine tubes, cervical applicators, surface plaques, etc., showing methods of filtering radiation.

Philip Morris & Co., Ltd., Inc., 119 Fifth Avenue, New York City, manufacturers of Philip Morris cigarettes, has been studying the effects of smoking on irritation of the mucous membrane of the upper respiratory tract, and one of its research staff will be present to explain the work and the results obtained. Samples of Philip Morris cigarettes will be distributed.

Lea & Febiger, 600 South Washington Square, Philadelphia, Pa., will occupy booth 1 and will exhibit new and important publications, including *Graham, Singer and Ballon's Surgical Diseases of the Chest, Wiggers' Physiology,* Clapp on Cataract, and new editions of Bridges' Dietetics, Fishberg's Hypertension, Kanavel's Infections of the Hand, Musser's Internal Medicine, and many other important books. Mr. H. J. Cowell will have charge of the booth.

The C. V. Mosby Company, 3523 Pine Boulevard, St. Louis, will exhibit its complete volume of medical publications. Among the new volumes to be displayed will be the following: New editions of Clendening "Methods of Treatment", Sutton "Diseases of the Skin", Macleod "Physiology in Modern Medicine", Elmer-Rose "Physical Diagnosis"; a new book by Gradwohl on "Clinical Laboratory Methods and Diagnosis", and the popular leaders of 1934: Key & Conwell "Management of Fractures, Dislocations and Sprains", Hertzler "Surgery of a General Practice", Dodson "Synopsis of Genitourinary Diseases" and Zahorsky "Synopsis of Pediatrics". Visitors to the convention are cordially invited to see our display.

Food Concentrates, Inc. (sponsored by the United Fruit Company), Pier 3, North River, New York City, manufactures the following banana foods for infants and children: *Melotose No. 1*—Dried Ripe Banana. Fine Ground. Council-Accepted. *Melotose No. 2*—Dextrose, Dried Ripe Banana and Malt Extract. *Melotose No. 3*—Milk Sugar and Dried Ripe Banana. These products will be shown in booth 3.

The Way Agency, Inc., 605 Broad Street, Newark, N. J., will explain the automobile plan accepted by The Medical Society of New Jersey.

The Walker-Gordon Laboratory Company, Inc., Plainsboro, N. J., invites you to stop at booth 26 and try its *Certified Vitamin D or Acidophilus Milk*. Representatives of the company will be present to give the Medical Profession information on the various lines of research in milk production which is being carried on by the company.

The Gerber Products (Fremont Canning Co.), at Booth No. 2, will show the *Gerber's Strained Cereal, Vegetables, and Prunes* and give out information concerning the new shaker-cooker process which has just been announced.

Booklets and leaflets are available. Some of these are suitable for distribution by physicians, and some are for professional use only.

Health Products Corporation, 113 North 13th Street, Newark, will exhibit *White's Cod Liver Oil Concentrate Tablets* in booth 29. Each tablet is equivalent to a full teaspoonful of a high potency cod liver oil. It is economical, stable, pleasant tasting, scientifically honest, and therapeutically effective, and is accepted by the Council on Pharmacy and Chemistry of the A. M. A.

The Holland-Rantos Company will display its gynecological specialties including the *H-R Koromex Diaphragm* and *Koromex. Rantosilk* and *Surgitex*, new waterproof fabrics, will be featured in some of their many forms such as aprons, sheets, and throws. Other products displayed include the *Powdex Insufflator, Powdr-Pufr*, and *Rantos Lubricating Jelly*.

NEW PHYSICIAN'S LIEN LAW—CHAPTER 146—LAWS OF 1935

After intensive effort on behalf of Dr. Weigel's Committee, the Board of Trustees, and President Ely, S-134 was passed by both Houses of the Legislature and signed by the Governor on March 26, 1935.

This bill was prepared by Senator Leap, as Attorney for The Medical Society of New Jersey, and introduced by Senator Hendrickson from Gloucester County. The bill had the support of the New Jersey Bar Association and the Insurance Carriers. Many of our supporters in the Assembly were absent when the vote was taken just before adjournment, but the only opposition was raised by certain younger lawyers in the Assembly.

The Assembly vote is recorded below:

VOTED FOR S-134

Assemblyman	County
Adler	Cumberland
Altman	Atlantic
Betts	Essex
Bien	Essex
Bischoff	Hudson
Bowers	Somerset
Burke	Middlesex
Burrell	Essex
Clee (Speaker)	Essex
Cunard	Salem
DeCamp	Essex
Eber	Essex
Gilmore	Passaic
Giuliano	Essex
Goldberg	Essex
Gurk	Gloucester
Hand	Essex
Jamieson	Mercer
Katzenbach	Mercer
Maloney	Hudson
McKinstry	Middlesex
McNaughton	Passaic
Muir	Union
Pascoe	Union
Paul	Essex
Rafferty	Middlesex
Riggs	Morris
Sanford	Essex
Van Fleet	Union
von Nieda	Camden
Vorsanger	Bergen

VOTED AGAINST S-134

Assemblyman	County
Artaserse	Hudson
Beronio	Hudson
Hunziker	Passaic
Kerner	Union
Knight	Monmouth
McAlevy	Hudson
McCauley	Hudson
Moroney	Warren
Pesin	Hudson
Sikowski	Hudson

CONFERENCE OF HEALTH OFFICIALS

The twenty-fifth annual Conference of State and Local Health Officials of New Jersey was held on the afternoon and evening of Friday, February 15, 1935, in the Assembly Chamber of the State House in Trenton, with Dr. S. A. Cosgrove, President of the State Department of Health, presiding. About 225 officials were present from the 564 municipalities which constitute the local health units of the State. The absentees were mainly from the smaller units but all the more important districts were represented.

The program was opened with a discussion of the subject "The Use of Free Toxoid and Vaccine by New Jersey Physicians", by William H. MacDonald, Chief, Bureau of Local Health Administration, New Jersey Department of Health. His paper was a discussion of the "Public Health Hour" project promoted by The Medical Society of New Jersey in cooperation with the State Department of Health. Dr. LeRoy A. Wilkes, Executive Secretary of the State Medical Society, presented the same subject from the point of view of the practicing physicians.

The remarks of both speakers and of the discussors on the floor showed that conditions existed which were not anticipated when the project was introduced. One condition is the apathy of the people when no epidemic is immediately threatening; and another is the persistence of the people in expecting service to be given in the spectacular clinic rather than the privacy of the doctor's office.

The leading position of a medical subject in the numbers of the program and the inclusion of the Executive Secretary of the State Medical Society as a speaker are evidences of the friendly coöperation between the Health Department and The Medical Society of New Jersey.

Mr. Cecil K. Blanchard, Assistant Epidemiologist of the State Department of Health, discussed the subject "Gain Support with Your Yearly Report", urging the health officials to clothe their reports in popular language which the newspapers can use as readable news, and to give such reports publicity. A report of the Township of Maplewood, an unincorporated suburban community of about 22,000 population, was shown as an excellent example of a popular board of health report. This reports was in the form of an eight-page mimeographed booklet with illustrations and descriptions of immunizations, anti-tuberculosis work, child welfare, milk inspection, and other activities of the health officer. The report is attractive in form and has a most interesting appeal to the reader.

Dr. Irvin E. Deibert, Chairman of the State Shellfish Committee, described the program for keeping the shellfish of the state safe as a food. Delaware Bay and the extensive line of shallow inlets along the Atlantic Coast are ideal oyster growing areas which produce millions of dollars worth of food annually. The oysters are also becoming of increasing importance from a medical point of view. Its "dark" meat consists largely of digestive cells whose function is that of an embryonic liver, containing vitamins and a trace of copper. A diet of oysters is therefore of value in conditions in which liver therapy is indicated. Oysters are now grown and handled under hygienic conditions, certified by the State and the United States Public Health Service.

Problems in venereal disease control, especially by educational methods, were discussed by Mr. Carl Daines, Supervisor, Social Hygiene Education, State Department of Health. Mr. Daines explained the methods of the Department of Health in investigating cases, and distributing material for treatment, and supplying speakers for lectures and interested groups.

The papers were discussed by the health officials, and many practical questions asked by them were answered.

The program of the evening session consisted of three numbers.

Motion pictures were shown, exposing the automobile as "Public Enemy Number One" as a source of accidental deaths.

The subject of "Bacillary Dysentery" was presented by Dr. Wade H. Frost, Professor of Epidemiology of the Johns Hopkins Medical School, who called attention to its epidemicity in several areas in New Jersey, and the need that it be recognized, and preventive measures adopted similar to those against typhoid fever.

Dr. Maurice Brodie, Assistant Professor of Bacteriology, New York University, described the methods of immunization against infantile paralysis that have been made available during the past year.

The regular quarterly meeting of the New Jersey Health Officers' Association—the state organization of the health officers—was held on Saturday morning.

DIPHTHERIA IMMUNIZATION APPEALS

A. BY THE COMMITTEE ON PUBLIC HEALTH

The Committee on Public Health of The Medical Society of New Jersey has issued the following appeal to the members of the Society that they will support its project of diphtheria prevention.

Dear Doctor:

It is absolutely *vital* to the success of our *Physicians Public Health Recovery Program* that you send before April 15 to every family in your practice, having an infant or preschool child between six months and six years, a copy of the letter printed on page 235 of the April issue of The Journal, furnished by our Committee, these letters are now in the hands of the Chairman of your County Public Health Committee for free distribution.

Therefore, we request that you do the following specific things in order to assist your public health chairman in his effort to preserve for you the field of preventive medicine in your own office.

1. Find out how many families with infants and preschool children are on your office records. If you are in doubt, your stubs of deliveries during the past six years and a check up of your office records of families with small children will help you decide the number of letters you need.

2. Secure at once the number of copies needed of this letter from the public health chairman of your county medical society.

3. Fill in the names, dates, and hours left blank, and mail the copies to the patients before April 15. If you are too busy to do so, have your office nurse, or wife, or someone else fill in the letters, but be sure and *sign each letter personally.*

4. Secure a sufficient supply of the free state toxoid and vaccine points from the nearest State Health Department Station. If you do not know where this is, ask your county secretary, or public health chairman, or any full-time health officer.

5. Talk to your friends and patients about the fact that the doctor members of the Medical Society of New Jersey are endeavoring to immunize all of their own preschool patients before *National and New Jersey Child Health Day May 1.*

6. Immunize and vaccinate as many of your patients as possible and report them promptly on the state postal card; and the number of them to your County Public Health Chairman weekly from now to May 1.

This all seems elementary but it is essential that we stir you into prompt action after the bad winter slump in immunizations that followed our excellent December record.

Many state health agencies are pushing a general campaign for *diphtheria immunization* of as many children as is possible before May Day. If you, as a loyal and coöperating member, do this at once, our State Medical Society can announce on May Day that we have offered a definite opportunity and appointment to every preschool child in the practices of our 3,000 members for diphtheria immunization and smallpox vaccination. If we, representing organized medicine, can really accomplish this essential step by May 1, we are not only meeting our real responsibility to our own patients, but we also will effectively diminish a good deal of adverse criticism which has arisen recently throughout New Jersey, as to the actual ability of organized medicine to do jobs of this sort effectively and promptly. We are definitely on trial in this issue, and the results will show whether we can regiment ourselves in our own offices for the proper public health needs of our own patients, or whether outside agencies will regiment our patients largely elsewhere.

If each of you swing into immediate action on reading this letter and proceed vigorously to do your share, the campaign will be a success. Less than one uarter of our 300,000 preschool children in New Jersey have been immunized. Please get busy right away on your own preschool patients, and do your share to make this plan carry through by Child Health Day; and thus preserve for yourself and your fellow members the future of preventive medicine in your own offices. Let us get this job *done* and *well done* before May 1.

Yours for the success o forganized medicine

STATE PUBLIC HEALTH COMMITTEE,
Stanley Nichols, M.D., Chairman.

March 26, 1935.

B. BY THE STATE DEPARTMENT OF HEALTH

The State Department of Health has supplied The Medical Society of New Jersey with two forms of letters to be sent by the family doctor to the parents of children, reminding them of the service of immunizations to be given by the physician. Either one or both of these forms will be supplied on request, to the Public Health Committee Chairmen of the County Societies, or to the Executive Offices of the State Society for distribution to physicians who in turn will send them to parents on their visiting lists. The two forms are as follows:

Dear Mrs. ———:

You probably share with other mothers a dread of diphtheria and have thought many times of having the protective treatments of toxoid given to ———.

With this in mind, I am writing to you and numerous other parents who have sought my advice from time to time, to say that I strongly recommend immunization against diphtheria. All children should be protected long before they reach school age. The danger from diphtheria is greatest at that early age and they can be more easily protected then. The treatment is safe and simple, and is best given soon after a baby is six months old. However, it may also be used with good results on older children.

How easy it is for us to put off action, even when we have the best of intentions. To help you decide to act now, I am going to suggest that you bring ——— to my office for the immunizing treatments, on ———, between — and — o'clock.

I have arranged this special "public health hour" under a plan of the State Medical Society, which is coöperating with the State and local departments of health and other agencies, to stamp out diphtheria. During this special hour, diphtheria preventive treatments, and also vaccination against smallpox, will be given for a fee which will not cause hardship to any parent.

Yours for the Prevention of Disease,

——— ———,

Family Physician.

My Dear Mrs. ———:

Has your child been immunized against diphtheria or vaccinated against smallpox? You probably know that diphtheria, as well as smallpox, is preventable.

The New Jersey State and County Medical Societies have requested each physician to write to his patients in regard to this matter.

Coöperation of parents is most essential if we are to achieve our aim to eradicate these diseases. It is in this spirit that I, as your family physician, address this card to you. I suggest that you call at my office on ———.

——— ———, M.D.

ANATOMICAL PATHOLOGICAL SOCIETY

The Essex County Anatomical and Pathological Society gave a dinner in honor of Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, on the evening of February 28, in the Hotel Douglas, Newark, on the twenty-fifth anniversary of the founding of the Society. Dr. C. R. O'Crowley, President of the City Hospital Medical Staff was toastmaster.

Dr. Edward J. Ill gave Dr. Martland credit for the success of the Society.

Dr. Martland, in his response, said:

"The society, through its research work at City Hospital, has improved hospitalization conditions throughout the county."

"We are not asking for a larger hospital to compete with private institutions, but a modern hospital with modern equipment."

Mr. Franklin W. Fort spoke in condemnation of the principle that the way to prosperity was by excessive spending.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS

Diphtheria Toxoid

County	To Feb. 28	Average per Month	Month of March	Total to March 31
Atlantic	32	4.	129	161
Bergen	1411	176.3	380	1791
Burlington	17	2.1	7	24
Camden	216	27.	34	250
Cape May	25	3.1	10	35
Cumberland	55	6.8	7	62
Essex	1234	154.2	495	1729
Gloucester	274	34.2	65	339
Hudson	97	12.1	96	193
Hunterdon	65	8.5	16	81
Mercer	16	2.	8	24
Middlesex	773	96.6	25	798
Monmouth	340	42.5	28	368
Morris	100	12.5	137	237
Ocean	29	3.6	9	38
Passaic	716	89.5	153	869
Salem	20	2.5	27	47
Somerset	773	96.6	12	785
Sussex	377	47.1	1	378
Union	132	16.5	161	293
Warren	36	4.5	4	40
Totals	6738	842.2	1804	8542

Smallpox Vaccine

County	To Feb. 28	Average per Month	Month of March	Total to March 31
Atlantic	124	15.5	2	126
Bergen	520	65.	30	550
Burlington	49	6.1	4	53
Camden	215	26.8	3	218
Cape May	367	45.8	75	442
Cumberland	26	3.2	3	29
Essex	833	104.1	175	1008
Gloucester	234	29.2	30	264
Hudson	0	0.	0	0
Hunterdon	58	7.2	10	68
Mercer	19	2.3	3	22
Middlesex	609	76.1	6	615
Monmouth	25	3.1	0	25
Morris	226	28.2	109	335
Ocean	12	1.5	4	16
Passaic	695	86.8	138	833
Salem	19	2.3	8	27
Somerset	212	26.5	12	224
Sussex	10	1.2	0	10
Union	42	5.2	68	110
Warren	94	11.7	1	95
Totals	4389	548.6	681	5070

169TH ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY

Tuesday, Wednesday and Thursday, April 30, May 1 and 2, 1935

OFFICIAL EVENTS

1. Board of Trustees Meeting, Monday evening, 8.00 o'clock.
2. Judicial Council, Monday evening, 8.00 o'clock.
3. Nominating Committee Meeting, Tuesday evening, 8.00 o'clock.
4. House of Delegates.

First Session, Tuesday Morning, 9.30 o'Clock

ORDER OF BUSINESS

a. Appointment of Reference Committees.
b. Reception of Annual Reports of Officers and Committees.
Five minutes will be allowed to each officer or chairman to amplify or explain his reports. The reports are published in this Journal, pages 187-230, and reprints will be mailed to every Delegate and Alternate for his study and for his personal use during the meetings.
c. New Business.

Second Session Tuesday Afternoon, 2.30 o'Clock

A continuation of the Morning Session

Third Session, Wednesday, 12 o'Clock Noon

ORDER OF BUSINESS

a. Report of Nominating Committee.
b. Elections. (No other business.)

Fourth Session, Thursday Afternoon, 4.30 o'Clock

ORDER OF BUSINESS

a. Reports of Reference Committees.
b. Unfinished Business.

5. Conference and Dinner of County Secretaries and Reporters, Tuesday, 7.00 P. M.
6. Scientific Meetings.
   a. General meetings.
   b. Section meetings.

(See programs on pages 238-241.)

7. Woman's Auxiliary.
   a. Executive Board Meeting, Tuesday afternoon, 2.30 o'clock.
   b. General Session.
   c. Luncheon Session.

(See programs on pages 241-242.)

8. President's Banquet (dancing to follow) under the auspices of the Woman's Auxiliary, Wednesday evening, 7.30 o'clock.
9. Exhibits.
   a. Scientific.
   b. Commercial.
   c. Arts and Hobbies by members of the Society.

GENERAL SCIENTIFIC MEETINGS

First Meeting, Wednesday Morning, May 1, 1935

9:30 to 9:50 o'clock

1. Lympho-granuloma Inguinale, as a Causative Factor in the Production of Rectal Strictures
   Homer I. Silvers, M.D., Atlantic City

9:55 to 10:25 o'clock

2. Polyglandular Disease
   George Crile, M.D., Cleveland, Ohio

10:30 to 11 o'clock

3. The Treatment of Chronic Heart Disease by Total Thyroidectomy.
   David D. Berlin, M.D., Boston, Mass.

11:05 to 11:25 o'clock

4. Acute Osteomyelitis
   B. Franklin Buzby, M.D., Camden

Second Meeting, Wednesday Afternoon May 1, 1935

2:30 to 3:00 o'clock

1. Coronary Disease in Young People
   Paul Dudley White, M.D., Boston, Mass.

3:05 to 3:25 o'clock

2. Causes and Management of Premature Labor
   Robert A. MacKenzie, M.D., Asbury Park

3:30 to 3:50 o'clock

3. Functional Rest of the Nose in the Treatment of Upper Respiratory Infections
   Earl LeRoy Wood, M.D., Newark

3:55 to 4:25 o'clock

4. Some Phase of Coronary Disease (Title to be announced later)
   James B. Herrick, M.D., Chicago, Ill.

SCIENTIFIC SECTION MEETINGS

SECTION ON RADIOLOGY

Elwood E. Downs, Chairman; P. S. Avery, Secretary

First Meeting, Thursday Morning, May 2, 1935

9:30 to 12:30 o'clock

SYMPOSIUM: PRIMARY CARCINOMA OF THE LUNG

1. Roentgen Diagnosis
   William Klein, M.D., New Brunswick
2. Endoscopic Study
   Henry B. Orton, M.D., Newark
3. Histological and Pathological Diagnosis
   Sylvan E. Moolton, M.D., New York, N. Y.
4. Surgical Aspect
   Richard Diffenbach, M.D., Newark
5. Roentgen Therapy
   Milton Friedman, M.D., Newark

Second Meeting Thursday Afternoon, May 2, 1935

2:30 to 4:30 o'clock

SYMPOSIUM: CHILDHOOD TUBERCULOSIS

1. Roentgen Diagnosis
   Maurice McPhedran, M.D., Philadelphia, Pa.
2. Clinical Manifestations
   Samuel B. English, M.D., and J. Gross, M.D., Glen Gardner
3. Pathological Findings
   Chester C. Brown, M.D., Arlington

SECTION ON GASTRO-ENTEROLOGY AND PROCTOLOGY

Julius Gerendasy, M.D., Chairman; Sigurd W. Johnsen, Secretary

First Meeting, Thursday Morning May 2, 1935

9:30 to 10:00 o'clock

1. The Relation of Gall-Bladder Diseases and Gall Stones to Myocardial and Coronary Disease and Angina Pectoris
   Hyman I. Goldstein, M.D., Camden
   Discussors: Philip Marvel, M.D., Atlantic City; Jacob Polevski, M.D., Newark

10:00 to 10:30 o'clock

2. The Management of Colitis
   Manfred Kraemer, M.D., and Maurice Asher, M.D., Newark
   Discussor: R. L. Sharpe, M.D., Camden

10:30 to 11:00 o'clock

3. Clinical Interpretation of Jaundice
   Victor Knapp, M.D., Asbury Park
   Discussors: A. R. Cassilli, M.D., Elizabeth; Harold K. Eynon, M.D., Collingswood

11:00 to 11:30 o'clock

4. Common Disorders of the Digestive Tract, a Clinical and Roentgenographical Study of 500 Private Cases
   S. W. Johnsen, M.D., Passaic
   Discussor: George H. Lathrope, M.D., Newark

11:30 to 12:00 o'clock

5. The Surgical Treatment of Massive Hemorrhage from Peptic Ulcer
L. G. Beisler, M.D., Newark
Discussors: Max Danzis, M.D., Newark; Vincent Farmer, M.D., Hackensack

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Second Meeting, Thursday Afternoon, May 2, 1935

2:30 to 3:15 o'clock

1. The Diagnostic Studies in Pain with Reference to Abdominal Disorders
Emanuel Libman, M.D., Mt. Sinai Hospital, New York

3:15 to 3:30 o'clock

2. X-Ray Demonstration of Unusual Gastro-Intestinal Lesions
Louis L. Perkel, M.D., Jersey City

3:30 to 4:00 o'clock

3. The Relation of Colitis to Chronic Appendicitis
C. D. Smith, M.D., Paterson
Discussor: Frank C. McCormack, M.D., Hackensack

4:00 to 4:30 o'clock

4. The Modern Proctologic Clinic, Management of Common Conditions
Martin J. Synnott, M.D., Montclair
Discussor: J. L. Mathesheimer, M.D., Jersey City

SECTION ON THE EYE, EAR, NOSE AND THROAT

James A. Fisher, M.D., Chairman; W. E. Campbell, M.D., Secretary

First Meeting, Thursday Morning, May 2, 1935

9:30 to 10:00 o'clock

1. Clinical Versus X-Ray Study in Acute Mastoiditis
Charles W. Barkhorn, M.D., Newark
Discussor: W. James Marquis, M.D., Newark

10:00 to 10:30 o'clock

2. External Fronto-Ethmosphenoid Operation (Presentation of a patient two years after a bilateral operation)
Oram R. Kline, M.D., Camden
Discussor: R. A. Luongo, M.D., Philadelphia

10:30 to 11:00 o'clock

3. The Influence of Bone Structure on the Purulent Lesions of the Temporal Bone
Samuel J. Kopetzky, M.D., New York City

Second Meeting, Thursday Afternoon, May 2, 1935

2:30 to 3:00 o'clock

1. The Treatment of Cataract in History
William H. Hahn, M.D., Newark

3:00 to 3:30 o'clock

2. Operative Treatment of Squint
A. B. Reese, M.D., New York City
Discussor: A. E. Sherman, M.D., East Orange

3:30 to 4:00 o'clock

3. Non Magnetic Intra-Ocular Foreign Bodies with Special Reference to Their Removal
Illustrated with lantern slides
George H. Cross, M.D., Chester
Discussor: E. S. Sherman, M.D., Newark

4:00 to 4:30 o'clock

4. Infantile Glaucoma, Report of Cases
Illustrated with lantern slides
Willard G. Mengel, M.D., Camden
Discussor: Charles Littwin, M.D., Englewood

SECTION ON PEDIATRICS

Frederic M. Lathrop, M.D., Chairman; F. J. Krauss, M.D., Secretary

First Session, Thursday Morning, May 2, 1935

9:30 to 10:00 o'clock

1. Schuller-Christian's Disease
Sandor A. Levinsohn, M.D., Paterson

10:00 to 10:30 o'clock

2. Congenital Abnormalities of the Alimentary Tract Occurring in the Premature and New-Born Infant
Benjamin M. Joseph, M.D., Jersey City

10:30 to 11 o'clock

3. Childhood Tuberculosis: Contact Histories and the Lowenstein Test
M. James Fine, M.D., Newark
Discussor: Samuel B. English, M.D., Glen Gardner

11:00 to 12:30 o'clock

SYMPOSIUM ON ACUTE POLIOMYELITIS

4. A Successful Method for Vaccination Against Acute Anterior Poliomyelitis (By invitation)

John A. Kolmer, M.D., Research Institute of Cutaneous Medicine, Philadelphia, Pa.

5. Active Immunization Against Poliomyelitis: Experimental and Human Studies (By invitation)

Maurice Brodie, M.D., and William H. Park, M.D., Department of Health, New York City

Symposium by Discussors:
William H. Park, M.D., New York City
Chester R. Brown, M.D., Arlington
Robert A. Kilduffe, M.D., Atlantic City

Second Session, Thursday Afternoon, May 2, 1935

2:30 to 3:10 o'clock

1. The Relationship of Urban Living Conditions to Temperament
J. S. Plant, M.D., Newark

3:10 to 3:50 o'clock

2. Developmental Language Disabilities in Children (By invitation)
Paul Dosier, M.D., Research Associate Neurological Institute, New York City
Discussor: J. S. Plant, M.D., Newark

3:50 to 4:30 o'clock

3. The Institutional Treatment of the Epileptic Child
Banks S. Baker, M.D., Skillman
Discussor: I. Cooper East., M.D., Skillman

EIGHTH ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

April 30, May 1 & 2, 1935, in Haddon Hall, Atlantic City

OFFICERS

President	Mrs. A. J. Casselman
President-Elect	Mrs. Frederick Kinch
First Vice-President	Mrs. William A. Freile
Second Vice-President	Mrs. James Mason
Third Vice-President	Mrs. Robert Glenn Stone
Recording Secretary	Mrs. Marcus Newcomb
Corresponding Secretary	Mrs. O. R. Carlander
Treasurer	Mrs. Edward Clarke

ADVISORY BOARD

Mrs. James Hunter — Mrs. Harry Hubbard
Mrs. John Nevin — Mrs. Charles F. Adams
Mrs. H. Roy VanNess

DELEGATES TO THE WOMAN'S AUXILIARY OF THE AMERICAN MEDICAL ASSOCIATION

Delegates	Alternates
Mrs. George Rogers	Mrs. H. Corbusier
Mrs. H. Roy Van Ness	Mrs. Lancelot Ely
Mrs. Frank Nicholson	Mrs. John Nevin
Mrs. Wm. A. Freile	Mrs. Edward Waters
Mrs. Don A. Epler	Mrs. Theodore Teimer
Mrs. A. S. Fell	Mrs. Harry Hubbard
Mrs. H. H. Bowles	Mrs. George Orton

PAGES, ART AND HOBBY EXHIBIT

Miss Barbara Ely — Miss Elizabeth Orton
Miss Arabelle Hubbard — Miss Barbara Sealey
Miss Marie Van Ness

ATLANTIC CITY GENERAL COMMITTEE

General Chairman	Mrs. Samuel L. Salasin
Entertainment	Mrs. Carl Surran
Program	Mrs. Dan S. Renner
Credentials	Mrs. David B. Allman
Treasurer	Mrs. James Mason
Flowers	Mrs. Ruffian Stamps
Secretary	Mrs. Harrison Nickman
Tickets and Reservations	Mrs. A. J. Casselman
Music	Mrs. Raymond Williams
Exhibits	Mrs. Stanley McGeehan, Mrs. Ily Beir
Prizes	Mrs. Dudley Singer
Art and Hobby	Mrs. H. D. Corbusier, Mrs. Blair Stewart, Mrs. David Weeks

Mrs. Maurice Axilrod — Mrs. Percy Clark Joy
Mrs. Barney Barab — Mrs. Robert A. Kilduffe
Mrs. Richard Bew, Jr. — Mrs. Abraham Krechmer
Mrs. Robert A. Bradley — Mrs. Morton Major
Miss Elsie Casperson — Mrs. Manuel Malley
Miss Desalles Coreoran — Mrs. Anthony Merindeno
Mrs. Edwin Coward — Miss Nellie McGurran
Mrs. Bernard Crane — Mrs. George Poland
Mrs. Eugene Dalton — Mrs. Norman Quinn
Mrs. Harold Davidson — Mrs. Hilton S. Read
Mrs. Robert Durham — Mrs. Daniel Reyner
Mrs. Arthur Ewens — Mrs. Louis Rosenberg
Mrs. Louis Feinstein — Mrs. Ernest Shore
Mrs. Myrtile Frank — Mrs. Charles Sinkinson
Mrs. Clarence Garrabrant — Mrs. Sloan Stewart
Mrs. Samuel Gorson — Mrs. Walter Stewart
Mrs. Robert Grier — Mrs. Harry Subin
Mrs. Edward Guion — Mrs. Baxter Timberlake
Mrs. Elmer Hess — Mrs. Arthur Von Deilen
Mrs. Harry Hoffman — Mrs. L. M. Walker
Mrs. Brown Holoman — Mrs. Henry Weeks
Mrs. Charles Hyman — Mrs. Clarence Whims
Mrs. V. E. Johnson — Mrs. Lawrence Wilson
Mrs. Samuel Winn

PROGRAM OF THE AUXILIARY MEETINGS

Tea will be served in the Art and Hobby Room each afternoon 4 P. M. to 6 P. M.

Tuesday, April 30th, 8:30 P. M.
Garden Room
EXECUTIVE BOARD MEETING

Wednesday, May 1st, 9:30 A. M.
Garden Room
BUSINESS MEETING

Call to Order—President, Mrs. A. J. Casselman
Roll Call
Tribute to Departed Members—Mrs. James Hunter, Jr.
Reading of Minutes—Recording Secretary, Mrs. Marcus Newcomb
Report of Treasurer—Mrs. Edward Clarke
Report of Corresponding Secretary—Mrs. O. W. Carlander
Report of Standing Committees
Report of Nominating Committee
Election of Officers

Wednesday, May 1st, 1:00 P. M.
Rutland Room
AUXILIARY LUNCHEON
HOSTESS—*The Camden County Auxiliary*
Mrs. E. G. Hummel, Camden, in charge
Introduction of Honored Guests

Wednesday, May 1st, 2:30 P. M.
Garden Room
RECONVENING OF BUSINESS SESSION

Reports of County Auxiliary Presidents
Report of President—Mrs. A. J. Casselman
Installation of Officers
Inaugural Address—Mrs. Frederick Kinch, President 1935-36

Thursday, May 2nd, 2:30 P. M.
Garden Room
NEW EXECUTIVE BOARD MEETING

PRESIDENT'S BANQUET AND BALL

On Wednesday, May 1, 7:30 P. M., in the Rutland Room

Under the auspices of the Woman's Auxiliary—Mrs. Carl Surran, Atlantic City, in charge
Toastmaster, William J. Carrington, M.D., Atlantic City

1. Greetings, by Mrs. A. J. Casselman, President of the Woman's Auxiliary to The Medical Society of New Jersey.
2. Annual Address, Lancelot Ely, M.D., President of The Medical Society of New Jersey
3. Inaugural Address, President-Elect Marcus W. Newcomb
4. Entertainment by Rosini, Master of Miracles
5. Dancing in the Vernon Room, Haddon Hall Orchestra

HOSTESSES AND TICKET COMMITTEE

Mrs. A. J. Casselman, *Chairman*

County Presidents

Mrs. James North	Atlantic
Mrs. Alvah W. Bickner	Bergen
Mrs. G. E. McDonnell	Burlington
Mrs. Edward C. Pechin	Camden
Mrs. Allen Corson	Cape May
Mrs. Don A. Epler	Essex
Mrs. J. Harris Underwood	Gloucester
Mrs. Frank P. Nicholson	Hudson
Mrs. A. S. Fell	Mercer
Mrs. W. K. Campbell	Monmouth
Mrs. Alfred Woodhouse	Ocean
Mrs. Burt Botbyl	Passaic
Mrs. Lancelot Ely	Somerset
Mrs. H. H. Bowles	Union

PAGES FOR THE BANQUET

Miss Miriam Barbash	Miss Marye Harrold
Miss Viola E. Brown	Miss Harriet Hubbard
Miss Jane Burke	Miss Frances Lee
Miss Emily Carrington	Miss Mary Lee
Miss Mary Carrington	Miss Elizabeth Orton
Miss Nancy Corbusier	Miss Mary Roop
Miss Mary Lea Davis	Miss Marie Van Ness
Miss Barbara Ely	Miss Beatrice Williams

Mrs. K. Woodhouse

THE PRESIDENT'S RECEPTION COMMITTEE

State Ex-Presidents

Mrs. A. H. Lippincott	Mrs. John Nevin
Mrs. James Hunter	Mrs. Charles F. Adams
Mrs. H. Roy VanNess	Mrs. Harry V. Hubbard
Mrs. George L. Orton	Mrs. A. J. Casselman

and

Mrs. David B. Allman	Mrs. James McGuire
Mrs. Wm. J. Carrington	Mrs. Marcus Newcomb
Mrs. Coulter Charlton	Mrs. James North
Mrs. A. J. Davis	Mrs. E. C. Pechin
Mrs. Lancelot Ely	Mrs. Joseph Poland
Mrs. William A. Freile	Mrs. Dan S. Renner
Mrs. Clarence Garrabrant	Mrs. J. E. Roberts
Mrs. E. H. Harvey	Mrs. Samuel Salasin
Mrs. E. G. Hummel	Mrs. Theo. Senseman
Mrs. John S. Irvin	Mrs. C. H. deT. Shivers
Mrs. Charles Kaighn	Mrs. Blair Stewart
Mrs. Frederick Kinch	Mrs. Carl Surran
Mrs. James Mason	Mrs. Theodore Teimer
Mrs. James Massey	Mrs. David Weeks

Mrs. LeRoy A. Wilkes

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

APRIL				MAY			
2	Camden	11	Passaic	2	Hudson	9	Passaic
4	Hudson	11	Somerset	7	Camden	10	Atlantic
9	Cumberland	12	Atlantic	7	Cape May	14	Bergen
9	Bergen	16	Warren	8	Mercer	14	Sussex
10	Mercer	17	Middlesex	8	Ocean	15	Middlesex
10	Ocean	18	Gloucester	8	Burlington	16	Gloucester
10	Salem	23	Hunterdon	9	Essex	22	Monmouth
10	Union	24	Monmouth				
11	Essex						

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held March 8, 1935, at the Hotel Dennis, Dr. C. C. Charlton presiding. There were 15 members and guests present.

LEGISLATION

Dr. Lancelot Ely, President of the State Society was a guest and made a few remarks regarding the medical legislation now coming up, including a bill concerning the Medical Practice Act which will make it necessary for everybody who treats diseases to have exactly the same education in the basic sciences. Dr. Ely also mentioned that the ERA had greatly benefited many of the physicians of this State. He commented on the proposed changes in the physicians' lien law.

NEW MEMBERS

Applications for membership were received from Dr. G. L. Hayfield of Northfield, Dr. W. L. Eckner and Dr. P. H. Marvel of Somers Point, and for associate membership from N. J. Whitehill, D. D. S. of Atlantic City. They were referred to the Board of Censors.

Dr. D. J. M. Miller, of Ventnor was made an honorary member.

MEETINGS

A meeting of the Fifth Councilor District will be held at Woodbury April 19th, 1935. The speakers will be Dr. H. S. Read of Atlantic City and Dr. E. D. J. Beardsley of Philadelphia.

A representative of the Society is invited to a meeting of nurses to be held at the Y. W. C. A. on March 15th when the 8-hour plan for nurses will be discussed.

A letter from Dr. W. E. Perry, Secretary of the Atlantic City Medical Association stated that a meeting of that Society would be held at the Y. M. C. A., 1711 Arctic Ave., on April 10th. Dr. Perry requested that one of our members be present to open the discussion of the scientific paper.

Dr. Irvin reporting for the Medical Advisory Committee stated that a new ERA director was to be appointed or the present director reappointed and that it was possible that politics would enter into the set-up.

Dr. R. R. Rubba of Hammonton as Sanitary Inspector of that city cannot work under the ERA unless approved by this Society. A motion was passed that he have this approval.

Dr. Charlton reminded the members of the Art and Hobby Exhibit at the State Society Convention.

The question came up as to whether the Staff Nurses of the Hospital should be invited to the meetings of this Society and after some discussion the invitation was left to the discretion of the President.

An amendment to the Constitution concerning the Seal of the Society was unanimously adopted.

Dr. Allman, Treasurer, stated that there were still 25 members that had not paid their dues. He also asked Dr. Ely if he could give the society any reasons why the State Assessment should be so high. After a great amount of discussion it was decided to communicate with the Board of Trustees and to instruct our delegates to take this matter up at the coming State meeting. It was the concensus of opinion that the state assessment was unreasonable in view of the figures published regarding the amount of money on hand in the State Society Treasury, and the amount of expense it is under.

There was a discussion as to the advisability of having a separate business meeting each month due to the hurried manner in which this part of the meeting is carried out because of the lateness of the hour at which it begins. No definite action was taken.

Dr. Charlton announced that the April meeting would be held at the Hotel Traymore at which there will be a general and practical discussion of ear, nose, and throat problems.

SCIENTIFIC

The scientific paper, an extensive lantern slide discussion of "The Pathogenesis, Mechanism, and Treatment of Tuberculosis Cavities", was presented by Pol N. Coryllos M.D., Professor of Thoracic Surgery, Cornell University Medical School.

Dr. Coryllos has long been widely known for his experimental investigations in this field as well

as for his practical applications of them to the surgical treatment of tuberculous cavities and is, perhaps, the outstanding authority on thoracoplasty and similar operations.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Englewood Hospital on Tuesday, March 12th. Dr. David Corn, our president, presided.

The minutes of the February meeting were read and approved.

The minutes of the Executive Committee meeting as printed in the Bulletin were approved.

MEMBERSHIPS

The following were elected to membership:

Junior

Dr. Arnold A. Zacchino, Palisade.
Dr. Frank S. White, Teaneck.
Dr. Charles Tudor, Bogota.

Associate:

Dr. W. L. James (his regular membership is now in the Essex County Medical Society).

The following applications for membership were received:

Regular:

Dr. Addino Bernardien, Bergen Pines.

Associate:

Dr. H. Andrew Hendrickson, Edgewater.

COMMUNICATIONS

The following communications were announced:

The annual report of Dr. Stanley Nichols, Chairman of the Public Health Committee of the Medical Society of New Jersey. This report was referred to Dr. V. A. Blenkle, Chairman of our Public Health Committee.

A letter from Mrs. H. D. Corbusier in regard to the Art and Hobby Exhibit together with application blanks.

CONSTITUTION AND BY-LAWS

Dr. Donald B. Hull, Chairman of the Committee on the Constitution and By-Laws, read two proposed changes therein as follows:

Chapter III Section 2—add in the third line after the word New Jersey "and in neighboring States." At the end of this Section add the words "Associate membership dues shall be $5.00 per year."

Chapter VIII, strike out the word "seven".

Then in Article V in the Constitution under Officers and Elections, line three, substitute "Spring" for "January".

It was explained that the purpose of the proposed changes was to:

1. Allow the election of a physician to Associate membership who has his regular membership in a New York County Society and not in a New Jersey County Society.

2. To change the time of election of officers to conform to the time of election of officers of the Medical Society of New Jersey as has been requested by the State Society.

AUTOMOBILE INSIGNIA

Dr. J. H. Irwin announced the fact that illuminated insignias were being made for use as automobile tail lights at night for members of the Bergen County Medical Society. One illuminated insignia was demonstrated.

Dr. H. B. Wilson moved that the membership list be given to the manufacturer, Mr. Fred Webb of Closter. This motion was passed.

Dr. V. Farmer moved that 100 of the regular Bergen County Medical Society automobile emblems be purchased, to be sold to members. Motion was passed.

BERGEN PINES

Dr. David Corn announced that Dr. J. H. Irwin had been appointed as a member of the Board of Managers of Bergen Pines.

SCIENTIFIC

The meeting was then turned over to Dr. David Goldberg, Chairman of the Scientific Committee, who introduced Dr. Nathan Rosenthal, Associate Physician and Hematologist of Mt. Sinai Hospital, who spoke on "Recent Advances of Blood Dyscrasias in Children". Dr. Rosenthal described briefly the characteristics of many forms of anemia in children such as found in the following:

1. Universal Edema of Fetus.
2. Icterus Gravis Neonatorum.
3. Aplastic Anemia.
4. Osteosclerotic Anemia.
5. Erythroblastic Anemia.
6. Congenital Hemolytic Icterus.
7. Sickle Cell Anemia.
8. Gaucher's Disease.
9. HemorrhagicPurpura with Splenomegaly.

Dr. Rosenthal also gave a very comprehensive review of various forms of Leukemiae as they occur in children.

Dr. Allen O. Whipple, Director of Surgery of Presbyterian Hospital, stated that the "Splenomegaly" belonged to the so-called "Middle ground diseases". He gave the statistics of 92 cases of splenomegaly that had been performed at the Presbyterian Hospital over a number of years. The follow-up of these cases revealed that splenectomy gave good results especially in thrombocytopenia and hemolytic icterus.

Drs. Heller, Markley, Gilady, Polowe, and Franklin discussed the papers.

The meeting adjourned for refreshments.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The regular meeting of the Society was held Thursday evening, March 14th, at the Moorestown Field Club, Moorestown, N. J. The attendance was a record one. Interest in the meetings seems to be constantly growing.

Mr. Rex McCrosson, Executive Director of E. R. A. in Burlington County, gave a very comprehensive discussion of "Administrative and Financial Aspects of the Medical Phases of E. R. A. in Burlington County".

Most of the other business of the Society was dispensed with, in order to give appropriate time to the scientific program.

SCIENTIFIC

Dr. Joseph M. Kuder, Chairman of the Section on Surgery, introduced Dr. Eldridge L. Eliason, of Philadelphia. Dr. Eliason presented a most practical and interesting discussion of "Early Diagnosis for Abdominal Surgery".

Those in general practice, as well as the surgeons present, were delighted with Dr. Eliason's presentation.

After the formalities, the majority of those present discarded their cares for a time to "emulsify" sandwiches and beer.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held at nine p. m. Tuesday, March 5, 1935.

The guest speaker was Dr. Harrison S. Martland, who gave an interesting description of "The Work of the Medical Examiner in Essex County." He undoubtedly convinced the membership of the advantages of the medical examiner set-up over the antiquated coroner system. Dr. E. B. Rogers, and the guests of the Society: Mr. Clifford Baldwin, ex-prosecutor; Samuel M. Orlando, prosecutor and Walter S. Keown, County Solicitor all of Camden County, joined in the discussion.

Statistics of the City of Camden reveal the fact that for the year 1933, of all the deaths 26 per cent were coroner's cases, of which 29 per cent were autopsied. For 1934, of all the deaths 24 per cent were coroner's cases, of which 33 per cent were autopsied.

City of Camden only	1933	1934
Total Deaths	1,532	1,644
Coroner's Cases	401	397
Autopsies	119	133
Auto Accidents	82	83
Suicides	30	17
Homicides	23	9

The following doctors were admitted to membership: Drs. Geo. Grenhart, 430 Haddon Ave., Camden, Frank F. Moore, 201 Evergreen Ave., Woodlynne and Everett Hemphill of Camden.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

Vice-President Anthony Charles Zehnder presided at the regular meeting of the *Essex County Medical Society* held at the Academy of Medicine, Newark, Thursday evening, March 14, 1935.

Two eminent speakers were guests. Dr. William H. Park spoke on "The Newer Preventives of Diphtheria, Precipitated Toxoid and Toxoid Flocculi."

Dr. Maurice Brodie spoke on "Immunization Against Poliomyelitis" describing phrases of the technical development of his preventive vaccine. He told of the vaccination of five children the week before, that marked the commencement of activities of the Babies Hospital Coit Memorial Infantile Paralysis Prevention Center in Newark.

FOOD FADISM

A special committee of the society composed of Doctors R. N. Connolly, C. R. O'Crowley and A. Charles Zehnder submitted the following report which was endorsed by the society unanimously.

Mr. President and Fellow Members:

At the last meeting of the Council, held on February 25th, 1935, the attention of the members was called to the fact that a large Newark department store recently sponsored a well advertised programme, extolling one of the most unscientific and unreliable diet fads of the day.

The advice given the speaker at the two lectures delivered by him in Newark was not only pernicious and dangerous, but also a menace to public health, because of the claim he made that his diet can cure many of the grave diseases with which mankind is afflicted.

This diet fad and its exploiter had previously received attention from the Investigation Bureau of the American Medical Association, which resulted in reports condemning the method as being contrary to the well-known laws of physiology. These reports also describe the speaker as having left a trail behind him in many of the places in which his activities had formerly been carried on.

The following is quoted from a report of the Bureau of Investigations of the A. M. A., published in the Journal under date of November 25, 1933:

"Dr. Hay appears to have been active some years ago in the American Association for Medico-Physical Research, another of the "twilight-zone" organization This concern was dealt with at some length by the Bureau of Investigation in an article published in The Journal of September 19, 1925. Dr. Hay was also prominent in the so-called Defensive Diet League of America, being a member of its "Medical Advisory Board". The Bureau of Investigation published an article on that concern in The Journal of June 20, 1925. More recently Dr. Hay seems to have joined that group of faddists who obtain publicity by disseminating propaganda against the use of aluminum cooking utensils.

The speaker's entire dietary scheme was exploded by the thoroughly exhaustive and scientific investigation of this subject made at the Jefferson Medical College by Prof. Martin E. Rehfuss, in his articles entitled "Proteins Versus Carbohydrates", which appeared in the A. M. A. Journal for November 24, 1934. Reprints of both of the above-mentioned articles may be obtained upon application to the A. M. A.

With these facts in mind, your Special Committee respectfully submits the following:

RESOLVED, that the so-called Hay Diet as a sure cure for the diseases enumerated by Dr. Wm. H. Hay in his lectures at Kresge's Department Store in Newark, has been shown to have no value, and his reasoning regarding the processes of di-

gestion is based on a wilful disregard of or a lack of knowledge of the laws of physiology which govern digestion.

IT IS FURTHER RESOLVED, that the Essex County Medical Society express its disapproval of this method of preying upon the public under the cloak of scientific medicine, and that in this case we consider it especially flagrant because the exploitation received the sponsorship of a large business institution.

IT IS FURTHER RESOLVED, that this Society recommend that its members warn their patients of the danger of blindly following the advice of any man who has a health fad to sell.

GLOUCESTER COUNTY

H. B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held in the Hotel Pitman, Pitman, N. J., on the evening of March 21, with the following members present.

Drs. W. J. Burkett, M. F. Lummis, I. W. Knight, and Victor I. Barrows, of Pitman; Louis Ruttenberg, Mantua; H. B. Diverty, Paul M. Pegau, Dorothy Rogers, E. E. Downs, Duncan Campbell, J. Harris Underwood, W. E. Crain, Ralph Moore and Fuller G. Sherman, of Woodbury; H. W. Wright and Horace M. Fooder, Williamstown; Don Weems, Wenonah; Oran A. Wood, H. L. Sinexon, and C. C. Sheets, of Paulsboro; Irving J. Stewart and N. A. Livengood, of Swedesboro; C. I. Ulmer and T. I. Gairdner, of Gibbstown; R. K. Hollinshed and Edward R. Ristine, Westville, and William Pedrick, of Glassboro. Visiting delegates included Dr. C. P. Sheaffer, Camden; Dr. H. G. Miller, Cumberland; Drs. Crow and Pettit, Cape May, and Drs. White and Marble, Atlantic.

Announcement was made that the Society will be hosts to the meeting of the Fifth Councilor District, to be held on the afternoon of April 18, at the Woodbury Country Club.

A post graduate course of lectures sponsored by the State Medical Society and the Rutgers University Extension Service will start in April, and will include two diagnostic clinics in Camden Hospitals.

SCIENTIFIC

Dr. Wayne Babcock, Professor of Medicine in Temple University Medical School gave an address on "Carcinoma of the Intestinal Tract", illustrated with lantern slides, motion pictures, and still pictures in colors.

Following the meeting the ladies of the Auxiliary joined the Society for a buffet supper.

HUDSON COUNTY

John N. Connolly, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, March 5, 1935, at the Carteret Club. The meeting was called to order by the President, Dr. Chapman, at 9:30 p. m.

The minutes of the preceding regular meeting having been printed in the Bulletin, were accepted as printed.

Dr. Chapman accepted a motion that the minutes of the Executive Committee meeting, which were printed in the Bulletin, be received and their recommendations acted upon.

WELFARE COMMITTEE REPORT

Dr. Pollak, Chairman of the Welfare Committee, reported that the Welfare Commtitee of the State Society had asked him to get in touch with our Senators and Assembly delegates from Hudson relative to the amendment of the Physicians' Lien Law Bill, known as the Committee Substitute of Senate No. 134. The report from the Executive Office in Trenton stated that the insurance companies and lawyers were in favor of it.

Dr. Pollak interviewed Senator Stout and others and was promised their support.

PARKING REGULATIONS

Dr. Thomas Higgins, Chairman of the Publicity Committee, gave his report on the new privileges granted the doctors of Hudson County by the police with reference to certain traffic and parking regulations.

Dr. Schwarz moved that the Secretary be directed to send a letter of thanks to the Commissioner of Public Safety.

CONSTITUTION AND BY-LAWS COMMITTEE REPORT

Dr. Barbarite stated that the Committee has now changed the record in the Constitution as follows:

"The Committee on Medical Economics shall consist of 27 members who shall be appointed by the President. Nine members shall be appointed each year and hold office for a term of 3 years. It shall elect its own chairman. It shall obtain all possible data on all economic measures affecting, directly or indirectly, the medical profession. It shall coöperate with the Legislative Committee in legislative matters which effect the economic status of the profession. It shall be subject to direction or approval of the Executive Committee and of the Society. It shall report from time to time its activities and shall render an annual report to the Society. Upon the adoption of this By-law nine members shall be appointed for a term of 3 years, nine for a term of 2 years and nine for a term of 1 year."

MEDICAL ECONOMICS COMMITTEE REPORT

Dr. Pyle, the Chairman of the Medical Economics Committee, stated that during the last fall and winter several letters had been received by the Economics Committee with reference to re-opening the question of the E. R. A. Plan in Hudson County. Dr. Pyle read a letter from Dr. S. C. Braunstein which was as follows: "As Secretary of the North Hudson Physicians Society, I have been ordered by the February 25th meeting, to notify the County Society that we have gone on record as being in favor of the E. R. A. for Hudson

County, and that we desire a special meeting for the purpose. (Signed) S. C. Braunstein, M.D."

The following letter was read from the Bayonne Medical Society: "The Bayonne Medical Society wishes the Hudson County Medical Society to take cognizance of the following resolution that was passed by their regular meeting: "The Bayonne Medical Society, having adopted a resolution favoring the New Jersey Medical E. R. A. Plan at the November meeting, wishes to inform the County Medical Society of its action, and urges the Society to reconsider its previous action in not adopting the plan, or to aid the Bayonne Medical Society in its efforts to have the E. R. A. Plan work in the City of Bayonne. (Signed) L. K. Morgenstein, M.D., Secretary."

Dr. Pyle stated the matter was referred to the Economics Committee and was discussed at two or three meetings. It was decided the Committee should express no opinion on the matter, but should collect data from the State on the operation of the E. R. A. and present it to the County Society and let the Society decide whether or not it wishes to reconsider the matter. Accordingly, a questionnaire was sent to the secretaries of the various County Societies, to the Chairmen of the various Emergency Relief Administrations, and to some individuals.

Dr. Pyle then read in detail all of the replies to the questionnaire. Dr. Chapman placed the matter before the Society for discussion. Dr. M. Shapiro moved that the County Medical Society rescind its previous action and adopt the E. R. A. This motion was discussed by Drs. Schwarz, Braunstein, Norton, Maras and Pyle. After the discussion the motion was reconded and almost unanimously passed. Dr. Evans moved that a Committee of five be appointed to contact the proper authorities; and that the Chairman of the Economics Committee be on that Committee. Dr. Chapman stated that this should be a Sub-Committee of the Medical Economics Committee, who will select five men to act as its Sub-Committee.

SCIENTIFIC SESSIONS

1. Pilonidal Sinus, by Joseph Raymond Connors, M.D., New York City.
2. Colitis from the practitioner's standpoint, by Anthony Bassler, New York City.

The meeting adjourned at 12.15 p. m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on March 13th, Vice-President Robert G. Stone, M.D., presiding. The reading of the minutes was suspended until after the scientific discussion.

SCIENTIFIC

The speaker of the evening, Dr. C. T. Jones, Superintendent of the State Colony at New Lisbon, was introduced by Dr. Stone.

Dr. Jones rendered a most interesting report of the work being done at that institution, laying particular emphasis upon the recent developments in research along the lines of special types of Defective Delinquents.

The description of the endeavor to define, diagnose, and segregate certain types of feeble-minded, for the purpose of classification and concentrated efforts, was not only entertaining but educational, thus eliciting favorable comment and desire for further enlightenment relative to the conduct of and management assumed by those responsible, in our several State Institutions.

Dr. Jones was accorded a rising vote of appreciation, and extended a most cordial invitation to the members of the Medical Profession to visit the Colony.

POST-GRADUATE

Dr. J. F. Pessel, temporary Chairman of the Post-Graduate Committee, made a report of the subjects to be covered and appealed for support of the undertaking.

Following considerable discussion relative to the time of holding the lectures, the motion was made by Dr. Adams and seconded by Dr. Chianese that the program as submitted by the committee be accepted. The motion was carried.

Dr. Sommer called attention to the fact of the Court approval of the Fee Schedule, and stated that further legislation was in process.

Drs. Haggerty and McGuire delivered considerable information relative to the progress of medical legislation, emphasizing the necessity of retaining a most vigilant and resourceful watchfulness over proposed legislation.

NEW MEMBERS

Dr. Charles F. Cella was elected to active membership, and Drs. K. F. Metzger and Robert F. Rapp to associate membership.

The application of Dr. Frank P. Guidotti was read and referred to the Membership Committee.

INVITATION FROM BUCKS COUNTY, PA.

Dr. J. Fred Wagner, Chairman of the Program Committee of the Bucks County Medical Society, submitted a cordial invitation to our Society, to hear Dr. A. C. Christie, of Washington, D. C., speak on the subject "The Doctor and Social Insurance" on May 8th, 1935, in the Court House, Doylestown, Pa.

INVITATION TO BIRTH CONTROL LECTURE

The Maternal Health Center Committee extended an invitation to the society to hear Mrs. Margaret Sanger, Chairman of the National Committee for Birth Control, speak on the subject "Birth Control and Its Social Aspects" at a meeting to be held March 25th at 8 o'clock in Junior School No. 3.

PROGRAM APRIL 10

Dr. Clarence Patten—subject, "Vegetative Nervous Diseases in Relation to General Medicine"—will address the meeting, to be held April 10th.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

EXECUTIVE COMMITTEE REPORT

A meeting of the Executive Committee of the *Monmouth County Medical Society* was held in the Fitkin Memorial Hospital, Neptune, February 11, with the following members present: Drs. Fairbanks, Parry, Kazmann, Hunt, Pregnall, Prout, Fisher, Blaisdell, Holters, Gosling, MacKenzie and Featherston.

ECONOMIC COMMITTEE

Dr. Blaisdell read a report from the Economic Committee which was discussed at some length. The subjects covered in the report included the Doctors' Lien Law, Health Insurance, Service Companies to Finance Bills, and Rules for Hospital Clinics. Each subject was discussed individually and the entire matter was referred back to the Economic Committee to be tabulated and submitted to the Society as a whole.

LIAISON PROJECT OF WOMAN'S AUXILIARY

Dr. Fairbanks read a letter from Dr. Ely, President of The Medical Society of New Jersey, in which he outlined a publicity project conducted by the Woman's Auxiliary in an effort to bring the medical profession into close relation with the lay health organization and general public. Dr. Ely urged us to provide the Chairman in our county with a list of medical speakers on popular health subjects. The matter was referred to the Public Relations Committe.

E. R. A.

Dr. Jesse L. Roark, of Belmar, and Dr. Charles Fromkin, of Keansburg, submitted applications to do work for the Emergency Relief Administration. Their applications were accepted, and the E. R. A. was instructed to place their names on the approved county list.

A meeting of the Executive Committee was held with representatives from the County Emergency Relief Administration, headed by the director, Mrs. Louise Bodman, in the Monmouth Memorial Hospital, Long Branch, on Wednesday evening, February 20th.

The question of eye refractions was brought up for discussion and it was agreed that a charge of $2.50 was a fair fee for an eye examination if drops were not used, as this would probably only require one visit. However, if drops were used which necessitated at least two visits, a charge of $5.00 would be a fair fee.

The matter of delay in reporting calls made by the doctor and the request for authorization for subsequent calls was discussed. As it is a state regulation, it is felt that the burden of this matter rests with the doctor, and the E. R. A. directors and supervisors were within their rights in refusing authorization on calls already made if the 40-hour ruling is not complied with. The question of one call in an emergency was not included in this discussion.

The rules and regulations of the Medical Agreement with the E. R. A. have not in some instances been supplied to all physicians. If the physicians who have not received a copy of these rules will call Asbury Park 3809, they may receive a copy of same.

The matter of prescriptions was brought up for discussion. It was pointed out that, when the *official* prescription blanks are used, it is not necessary for the E. R. A. client to return to the local office for the authorization before having the prescription filled. If the prescription is written on the *doctor's personal blank*, the client must go to the E. R. A. headquarters in his district for authorized blanks before obtaining the medication. It is again brought to the physician's attention that all prescriptions are to be written from the National Formulary, and remedies not included in this manual are not to be used.

FEBRUARY MEETING OF THE COUNTY SOCIETY

The February meeting of the *Monmouth County Medical Society* was held in the Auditorium of the Jersey Central Power & Light Company, Allenhurst, New Jersey, Wednesday evening, February 7, at 8.30 o'clock, with President Dr. W. H. Fairbanks presiding. Approximately fifty members were present.

The minutes of the January meeting were read and approved and the Executive Committee's report was accepted.

Dr. M. J. Lorenzo, of Red Bank, New Jersey, was elected to membership.

E. R. A.

A communication was received from the State E. R. A., inviting all members of the E. R. A. Committee of the Monmouth County Medical Society to a State E. R. A. meeting, to be held in Trenton on Sunday afternoon, February 3. Important aspects of the Emergency Relief Administration were to be discussed and all committee members were urged to attend.

The Hudson County Medical Society, not having entered into a Medical Agreement with the E. R. A., requested certain information in regard to the practice of medicine in Monmouth County under E. R. A. jurisdiction. The request was referred to the Executive Committee.

The Society was informed that the new Bill, which has been planned as a substitute for the Physicians' Lien Law, was to be introduced before the State Legislature on Monday, February 4. The Secretary was instructed to advise the representatives of this County that the County Society was in favor of the passage of this Bill.

SCIENTIFIC SESSION

Following the business meeting, Dr. Fairbanks presented the speaker of the evening, Dr. Edward F. Roberts, of Lederle Laboratories, Inc., whose subject was "Management of Lobar Pneumonia".

Dr. Roberts, in reviewing statistical studies of the mortality in lobar pneumonia, brought out the following facts:

1. The mortality of pneumonia is materially increased when complicating pregnancy.

2. The mortality of pneumonia increases five times in the presence of pneumococcic bacteremia. Specific serum decidedly prevents bacteremia.

3. The use of specific serum produces a marked decline in the mortality of Types 1, 2, and 7 pneumonia, when used early.

4. When serum is employed, the decrease in mortality is in reverse proportion to the time interval between the onset of the disease and administration of serum, up to four days. After four days the mortality is approximately the same whether or not serum is used.

Dr. Roberts then described and compared the various methods of typing sputum, laying particular stress on the Neufeld Method.

Following his paper, Dr. Roberts showed a motion picture on the "Management of Pneumonia" as it is carried out at the Harlem Hospital under the direction of Dr. Bullowa.

HOSPITAL CONFERENCES

The Staff Conference of Fitkin Memorial Hospital was held Sunday morning, February 10, at 10.30 o'clock. The following program was presented:

Orthopedic Diseases of Puberty, Dr. Barclay Moffat

Lobar Pneumonia (2 cases), Dr. Frank Altschul

Malignancies of the Abdomen (2 cases), Dr. O. K. Parry

Carcinoma of the Tongue (2 cases), Dr. W. G. Herrman

Staphlococcic Septicemia (case), Dr. Samuel Edelson

The Staff Conference of Monmouth Memorial Hospital was held Wednesday evening, February 13, at 8.30 o'clock. The following program was presented:

Carcinoma of Tongue (case), Dr. W. G. Herrman

Carcinoma of Stomach (case), Dr. Walter Rullman

Hyperthyroidism (case), Dr. Joseph Wiener

Fibromyoma of Abdomen (case), Drs. Holters and Pons

Ablation Placentae (case), Dr. Robert A. MacKenzie

Case of Eosinophilia (for diagnosis), Dr. Joseph Wiener

PERSONAL NOTE

Dr. Robert A. MacKenzie, of Asbury Park, has been elected to Fellowship in the New York Obstetrical Society.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular quarterly meeting of the *Morris County Medical Society* was held the evening of March 21 at The New Jersey State Hospital at Greystone Park. President McMahon presided over an attendance of about forty members.

Dr. F. Clyde Bowers, of Mendham, New Jersey, was unanimously elected to membership.

Dr. Byron G. Sherman, member of the State Welfare Committee, reported having attended a very successful and complete meeting and will later make a full report of its actions.

SCIENTIFIC

The scientific chapter of the meeting was an address by Dr. Ralph A. Barrett, Attending Surgeon, Women's Hospital, New York City, whose subject was "Electro Surgical Treatment of Cervical Erosions and Cervicitis", with illustrative slide pictures. The speaker also demonstrated a radio tube electro coagulating machine and explained the technic of the various items of its equipment. Dr. Barrett's presentation held the close attention of his audience and elicited very general discussion with many questions that were adequately answered by the speaker. The crystalization of opinion was that he had struck something that was very much of a transition in surgical work. Dr. Barrett's presentation of his subject was enthusiastically received.

DATE OF ANNUAL MEETING

Action was taken according to the Constitution and By-Laws to change the schedule of meetings so that meetings would be held monthly with the exception of July and August, and to bring forward the Annual Meeting to June instead of September as it is now scheduled. The purpose of the change of date is to arrange the Annual Meeting more in conformity with the wishes of the State Medical Society and with each monthly meeting a regular meeting so that important business could be transacted more promptly rather than to have it postponed for 2 or 3 months or to call a special meeting to consider some particular matter that might require prompt attention. To carry this into effect a revision of the By-Laws was read and steps will be taken so that it may be acted upon at the June meeting.

MATERNAL WELFARE

Dr. Frost of the Maternal Welfare Committee described a meeting in Newark, reporting that of 780 cases in three hospitals, four deaths occurred; and referred to statistics from the State Board of Health showing 2821 deliveries outside of hospitals during the year 1934 with six deaths. He said that the committee will meet in the near future with Dr. Dare, who is Chairman of the U. S. Maternal Welfare Board; and that it is proposed this year to hold a series of meetings similar to the Clinical Club meetings that have been held by the Society

at the hospitals in Morristown and Dover. He also referred to certain things to be followed up as suggested by Temple University.

MEMORIAL TO DR. HENRY W. KICE

President McMahon referred to the recent death of Dr. Henry W. Kice who had served the Society long and faithfully, having been Secretary for twenty-five years and since his retirement as Secretary, the Historian of the Society.

COMING MEETINGS

President McMahon also announced that the next meeting would be a Clinical Club meeting at Dover General Hospital the evening of Thursday, April 18, 1935.

Attention was also called to the meeting to be held on April 11 at the Academy of Medicine in Newark of the First Judicial District, composed of the counties of Warren, Morris, Union and Essex, at which Dr. Glazebrook would speak; and that the State Medical meeting would be April 30 and May 1-2, being earlier this year so as not to interfere with the American Medical Association meeting.

An exceptionally interesting meeting closed with refreshments in the hospital cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

A special meeting of the *Passaic County Medical Society* was held at the Health Center, Paterson, on Friday, March 1, 1935, Dr. Wright MacMillan, President, presiding.

The revised By-Laws were read, and unanimously adopted.

DISPENSARY ABUSE

The Committee on *Dispensary Abuse* submitted the following report:

Your Committee on Dispensary Abuse recommends that the following regulations governing the operation of the dispensaries of the hospitals in Passaic County be put into effect:

1. These regulations are devised to conserve the interests of the *financially distressed patients* without permitting them to become *free clinic-minded.*

2. It is also hoped that *these regulations* will shift some of the present burden of the medical and surgical cases treated at the *dispensaries* to the *private physician.*

3. All cases, which at one time or another have been under the care of *a private physician,* shall be referred back to that physician; or in the event he has no physician, to a *neighborhood physician.*

4. The admitting clerk at *the dispensaries* will give the *patient a yellow card,* referring the *patient* back to the *physician.*

The yellow card reads as follows:

Front—

. . . . . has applied to us for free medical care and states that you are his medical advisor. Will you please inform us if he is a suitable patient for our Clinic?

. . . . . .

for the Clinic.

Back—

. . . . . of . . . . . is hereby recommended to the . . . . . Clinic for any care that your Clinic can give.

. . . . . , M.D.

5. After the *private physician* reads the yellow card he will proceed as follows:

a. He will treat the patient for *such fees* as he and the *patient* agree is fair.

b. He will treat the patient on a *deferred payment basis.*

c. He will treat the patient *free* or

d. Sign the bottom of the *yellow card,* and send the *patient back* to the *dispensary.*

6. It is understood that in all cases where the *First Visit* is an *Emergency,* that *the case must be treated immediately at the dispensary.*

7. In the event the *patient* is returned to the *dispensary* by *the private physician,* or the *neighborhood physician,* the following table will be used as a guide in determining elegibility as regards income:

One in the family	$12.00 per week
Two in the family	20.00 per week
Three in the family	22.50 per week
Four in the family	25.00 per week
Five in the family	27.50 per week
Six in the family	30.00 per week
Seven in the family	32.00 per week
Eight or more in the family, per capita	4.00 per week

Income to represent the entire amount received from all sources, rent, earnings, board. Also the earnings of employed children, not the board paid.

8. *The patient* should then have the law read to him, which is on the back of the yellow card:

"Any person, who by false representations with respect to the ability of such person to pay the usual and reasonable cost of medical and/or surgical treatment for such person, or another, shall secure such medical and/or surgical treatment from any State, County, Municipal or Charitable hospital, or institution, free or at reduced rates, or who shall by false representations as to his or her financial situation obtain from any department of public welfare or overseer of the poor of any County or Municipality, financial or other assistance in any form, shall be guilty of a misdemeanor."

"Chapter 141, Laws of New Jersey, 1932.

"*Penalty*: $1,000.00 fine or three years at hard labor or both."

He should then sign his name to the card quoting the law.

After a great deal of discussion the adopiton of the resolutions was moved by Dr. Willard, seconded, and unanimously adopted.

ECONOMIC SURVEY

Dr. Ginsburg, Chairman of the Committee on Economics then read an excellent summary of the Hoover Commission report on "Medical Care for the American People". This was discussed and the suggestion made that some sort of survey be made of the conditions confronting Passaic County.

The meeting was then adjourned.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The *Somerset County Medical Society* held its regular meeting at the Nurses' Home of Somerset Hospital on Feb. 14th, 1935. The meeting was called to order at nine o'clock by the President Dr. R. F. Hegeman.

Members present were Drs. Adams, Baker, Barbour, Brittain, Ely, Earp, Field, Flint, Flynn, Gray, Halsted, Hegeman, Lawton, Lukats, McConaughy, Meigh, Massey, Pogoloff, Panigressi, Renner, Smalley, Stillwell, Scott, Young, and Sferra.

The minutes of the last meeting were read and approved.

The censors reported favorably on the application of Dr. Day of North Plainfield and he was duly elected to membership in the Medical Society.

FEE SCHEDULE

Dr. Barbour, of the Fee Schedule Committee, rendered his report. Dr. Barbour also moved that the Society employ Mr. James Bowers to represent the Society in the handling of the Fee Schedule. The motion was carried.

CONSTITUTION

The following Amendment of the Constitution was presented by Drs. Ely and Lawton:

Chapter 2, Section 1. The Annual meeting of this Society shall be held on the second Thursday of June, and the Society shall meet thereafter on the second Thursday in October, December, February and April. Five members shall constitute a quorum for the transaction of business.

E. R. A.

Dr. Lawton then called the attention of the Society to a condition which has arisen here in Somerset where the Board of Trustees has given the E. R. A. permission to send its clients to the hospital clinics without the clients first having been seen by a physician. This, Dr. Lawton pointed out, struck at the very essence of our contract with the E. R. A., and he suggested that the Society take action. He moved after some discussion that the Somerset County Medical Society object that these patients, especially maternity cases, shall be admitted to the Somerset Hospital without first consulting a doctor. The motion was carried, and the President instructed Dr. Lawton and the Secretary to formulate a proper letter to be sent to the President of the Board of Trustees of the Somerset Hospital, a copy of this letter to the President of the Hospital Association, and one to the Medical member of the State E. R. A. Council, who is Dr. S. T. Snedecor of Bergen County.

SCIENTIFIC

Dr. Bela Schick of New York was the guest speaker of the evening. He addressed the Society on the practical aspects of diphtheria immunization, toxin-antitoxin, toxoid, and the Schick test. He also touched on other subjects as to the work done in immunizing against measles and anterior-polio-myelitis. The address was most interesting and he linked other recent laboratory work with its practical application.

Light refreshments were served and the meeting adjourned.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING FEBRUARY, 1935

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
John W. Tildon	72	Feb. 1, 1935	54 N. Clinton Ave., East Orange	Same	Pulmonary embolism. Arterio sclerosis.
Charles F. Souder	67	Feb. 1, 1935	42 Harding Road, Red Bank	Same	Chronic myocarditis. Senility. X-ray burns of both legs.
Augustine J. Molloy	62	Feb. 23, 1935	840 Boulevard, Bayonne	Same	Endocarditis.
Harry B. Harris	50	Feb. 12, 1935	47 Cleveland St., Orange	Same	Nephritis. Uremia.
John E. Pratt	84	Feb. 5, 1935	34 Thompson St., Dumont	Same	Coronary occlusion. Angina pectoris.
George F. Ralston	72	Feb. 3, 1935	829 Shore Road, Somers Point	Same	Chronic myocarditis.

THE WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETING

Reported by Mrs. George S. Laird

A meeting of the *Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey* was held March 11th, at the Hotel Douglas in Newark. Twenty members were present.

Mrs. Samuel L. Salasin, Chairman of Entertainment, presented the following programs:

FOR THE ANNUAL MEETING OF THE WOMAN'S AUXILIARY OF THE MEDICAL SOCIETY OF NEW JERSEY

Tuesday, April 30th:

8.30 p. m.—Executive Board Meeting.

Wednesday, May 1st

9.00 a. m.—Business Meeting.
Call to Order, President, Mrs. A. J. Casselman.
Roll Call.
Tribute to departed members, Mrs. James Hunter, Jr.
Reading of Minutes, Recording Secretary, Mrs. Marcus Newcomb.
Report of Treasurer, Mrs. Edward Clark.
Report of Corresponding Secretary, Mrs. O. W. Carlander.
Report of Standing Committees.
Report of Nominating Committee.
Election of Officers.
Installation of Officers.

1.00 p. m.—Auxiliary Luncheon, the members of the Camden County, Auxiliary, Hostesses. Physicians and Members of their families are invited. Tickets $1.50 each, with rebate allowed to guests of the Hotel—(American Plan).

2.30 p. m.—Reconvening of Business Session.
Reports of County Auxiliary Presidents.
Unfinished Business.
Report of President, Mrs. A. J. Casselman.
Inaugural Address, Mrs. Frederick Kinch, President 1935-36.
Appointment of Committee Chairmen.
Adjournment.

4.30 p. m.—Meeting of Post-Executive Board.

7.30 p. m.—Presidents' Banquet and Ball.
Physicians and members if their families are invited.
Tickets $2.50 each, with a rebate allowed to guests of the Hotel (American Plan).
Toastmaster, Dr. Wm. J. Carrington.
Greetings, Mrs. A. J. Casselman.
President's Address, Dr. Lancelot Ely.
Inaugural Address, President-Elect Dr. Marcus Newcomb.
Entertainment, Rosini, Master of Miracles.
Dancing, Haddon Hall Orchestra.

Tea will be served each afternoon in the Arts and Hobby Room, 4.00-6.00.

FOR THE ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Sunday, June 9th.

7.00 p. m.—Dinner to the National Board by the Woman's Auxiliary to the Medical Society of Delaware, at the Claridge Hotel.

Monday, June 10th.

10.00 a. m.—Pre-Convention Board Meeting. Library Room, Traymore Hotel.
1.00 p. m.—National Board Luncheon, Traymore Hotel.
2.30 p. m.—Pre-Convention Board Meeting, Library, Traymore Hotel.
7.00 p m.—Get Together Dinner, Ritz Carlton Hotel.
9.00 p. m.—Reception and Musicale, honoring the wives of the members of the Canadian Medical Society, Ritz Carlton Hotel.

Tuesday, June 11th.

8.00 a. m.—Southern Breakfast.
9.00 a. m.—General Meeting. Library, Traymore Hotel.
1.00 p. m.—Luncheon. Hackney's, followed by chair ride or sail-boat ride.
4.00 p. m.—Tea, Woman's Auxiliary Philadelphia County Medical Society.
8.00 p. m.—General Meeting A. M. A., Auditorium.

Wednesday, June 12th.

9.00 a. m.—General Meeting, Library, Traymore Hotel.
12.30 p. m.—Reception and Auxiliary Luncheon, Main Dining Room, Traymore Hotel. Hygeia Health Pageant.
7.00 p. m.—Entertainment, Steel Pier.

Thursday, June 13th.

9.00 a. m.—Group Discussions.
10.00 a. m.—Post Convention Board Meeting.
1.00 p. m.—Luncheon, Card Party, Style Show. Ritz Carlton Hotel.
7.00 p. m.—"Bring Your Husband Dinner", Traymore Hotel.
9.00 p. m.—President's Reception and Ball, Auditorium, Convention Hall.

Friday, June 14th.

9.00 a. m.—Golf Tournament. Northfield Country Club. Golf privileges every day for visiting ladies.
1.00 p. m.—Golf Luncheon.
9.00 a. m.—De Luxe Tour. An interesting trip through the South Jersey mainland, visiting the following historical points and commercial industries peculiar to this section. Leaving Atlantic City via Absecon and the Seaview Golf Club, the tour will pass Chestnut Neck Revolutionary War Monument; through the fishing villages of New Gretna and Tuckerton, visiting the Transatlantic Wireless-Radio Towers, erected before the World War by the Imperial German Government; through the Bass River

State Forest of Stunted trees; through the cranberry bogs of South Jersey, then the Renault Wine Cellars at Egg Harbor; visit Pleasant Mills, Weymouth, and Mays Landing; tour along the Egg Harbor River, famed during Revolutionary times for the shelter of vessels carrying contraband cargo; then to Atlantic City via Somers Point and Longport. Frequent stops are made on this trip, and luncheon is furnished enroute.

Atlantic County

Reported by Mrs. Anna M. Mally

The regular monthly meeting of the *Woman's Auxiliary* was held at the Dennis Hotel, Atlantic City, on March 8th, at 8.30 p. m.

Mrs. James North, President, introduced Mrs. S. C. Frederick as a new member.

Mrs. Bernard Crane brought in the report of the Nominating Committee, which named the following:

President, Mrs. Carl A. Surran.

President-Elect, Mrs. Daniel C. Reyner.

1st Vice President, Mrs. W. Blair Stewart.

2nd Vice President (nom. from floor) Mrs. Percy Clark Joy.

The nominating Committee recommended that Mrs. Lawrence A. Wilson, Mrs. Manuel J. Mally and Mrs. Robert A. Bradley retain their respective positions of Recording Secretary, Corresponding Secretary, and Treasurer.

A number of letters of thanks were read from clubs which participated in our Reciprocity Tea, which was a very successful affair. About two hundred persons attended it. Mrs. John F. Massey, our Public Relations Chairman, gave an interesting report of arranging speakers for several meetings of various lay organizations in the community.

A motion was passed to donate $5.00 to the Training school at Vineland, N. J.

Announcements were made of plans for the annual meeting of the State Society on April 30, and the A. M. A. convention and the Canadian Medical Convention, which will be held in Atlantic City on June 10. All of our members have been allotted definite tasks during the conventions.

Our annual Spring Luncheon will be held in conjunction with the Convention Luncheon on May first.

Bergen County

Reported by Mrs. Mrs. Charles Littwin.

The *Bergen County Auxiliary* met on March 12th at the Englewood Hospital.

A splendid report of the luncheon bridge, given for the benefit of the Philanthropic Fund at the Hackensack Field Club, was read by the Chairman, Mrs. McCauley.

The State Convention Delegates appointed were Mrs. Bicknor, Mrs. Corn, and Mrs. Kilts.

The Speaker of the evening was Dr. Levitas of Westwood, who spoke on "Preservation of Health in Middle Life". Periodic health examinations were particularly stressed.

After the meeting a very pleasant social gathering followed.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday afternoon, March the fourth, 1935, at the Y. W. C. A., in Fairmount Ave., the president, Mrs. Frank P. Nicholson, presiding.

It was voted to change the April meeting day—and to hold it on the second Monday instead of the first, so that the members may attend the meeting of the literature department of the Jersey City Woman's Club.

On April ninth, Mrs. L. F. Harter, of Teaneck, will open her home for a card party to benefit the Auxiliary; it will be a dessert bridge, at one o'clock. tickets seventy-five cents.

Report was made of the card party, held at the home of Mrs. E. G. Waters 39 Gifford Ave., on Wednesday, February 20, when we cleared over a hundred dollars.

The president appointed the nominating committee for the spring election, Mrs. John Connell, chairman. Mrs: Harry Perlberg, Mrs. Warren Duckett, Mrs. Louis Dodson, and Mrs. Timothy Gerney.

The chairman of entertainment, Mrs. Charles B. Kelley, offered the suggestion that instead of a spring luncheon and card party, we hold a supper dance, and invite the men.

More about this plan will be brought forward at the next meeting.

The president spoke of the Annual Convention of the State Medical Society, in Atlantic City, April thirtieth and May first and second; and also of the A. M. A. to be held in the same place in June.

It was voted to send twenty dollars to the state chairman of entertainment, ten for our own state society, and ten for the entertainment of the A. M. A.

The speaker for the afternoon was Mr. J. C. Reiss, of Newark, the oldest dispensing optician in New Jersey; his subject, Eye Education. He gave first a very interesting motion picture—showing the making of optical glass by mass production, from the crude mass of glass to the finished lens.

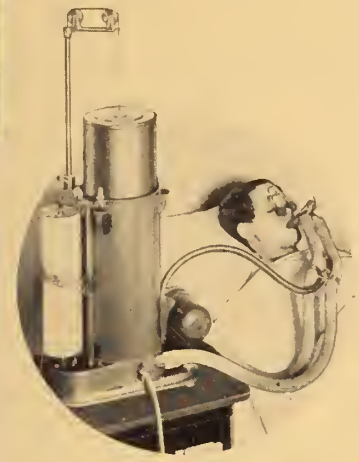
He then explained the proper way to make a lens; that each one should be ground separately, according to prescription.

He continued by telling us what a delicate operation it is, as special kinds of tools are necessary in the process.

The polishing of the lens must also be very carefully looked after; and take it all in all, there is very much more to the making of a lens than most people realize.

He begged us to be more than careful, where, and how we sought eye examination, and to be sure that we knew positively that the man we consulted was a man of professional standing, an authorized M.D., and not to drop in, any place along the avenue nor to pick up a pair of glasses promiscuously.

A social hour, with tea followed, when Mrs. Miles T. Long was the chairman of hostesses, assisted by a number of the members.



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Basal Metabolism Also!

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OF

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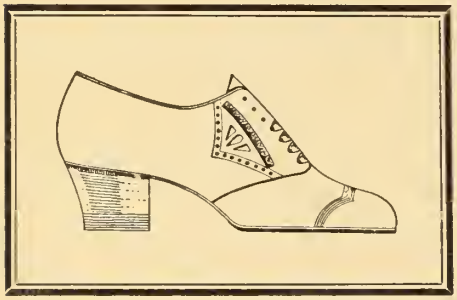
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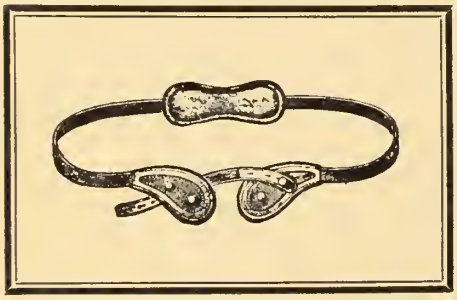
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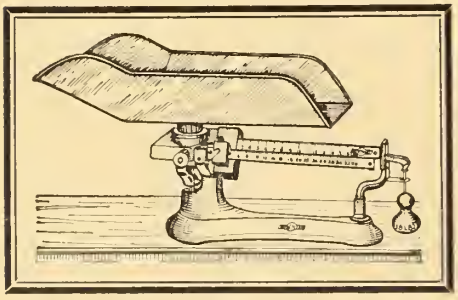
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EDITORIALS

Greetings from President Newcomb

The President of The Medical Society of New Jersey is charged with a broad leadership in all the fields of medical practice. The past year has been one of exceptional progress, especially toward the attainment of a unity of sentiment and action by the members of the medical profession of New Jersey. There has been a growing sentiment on the part of the public for a broadening of the scope of medical practice, fostered by high federal officials. Physicians must now give serious consideration to plans for imposing revolutionary methods for controlling the delivery of medical services through legislation by representatives who have neither the knowledge nor the experience to decide these great professional problems.

Legislators expect to receive the benefits of the advice of medical leaders supported by the united sentiment of the members of the Medical societies of the State. Experience has demonstrated the power of physicians and the members of the allied professions to direct the course of medical legislation along wise lines for the benefit of themselves and the public.

Your President assumes office in a time of emergency in which the inexorable course of events has placed him in a strategic position of experience and responsibility.

Groups of welfare workers and organizers of health associations are asking that the State assume a domination and control of the delivery of medical services; cultists are seeking an extension of their recognized fields of practice; and both groups are demanding immediate action. The answer which the medical profession gives to these demands in the near future will be a great factor in determining the course of medical practice for years to come. The major activity of your President is therefore predestined to be that of medical legislation.

The sentiments expressed in the House of Delegates justify the expectation that your President will receive the hearty support of the medical profession as he adopts the major activity of promoting medical legislation, even to the possible extent of leaving to others the responsibility of carrying on the other necessary activities of the State Society.

Marcus W. Newcomb, *President.*

The Annual Meeting

The three-day session of the Annual Meeting of The Medical Society of New Jersey which ended on May 2, was one of the most successful and satisfactory in the 169 years of the existence of the Society; in fact, it was the most successful, judged by the volume of its accomplishments.

The meeting afforded the first opportunity to judge the efficiency of the operation of the Society under the unification of its activities under an Executive Staff. For a year and a half the Executive Offices have been the center of the executive and editorial activities of the Society. The system was established late in the year 1933, and the Annual Meeting of 1934 was the first demonstration of the adaptability of the system of the needs of the Society. The year's accumulation of records since that time has resulted in a clearness of vision of past achievement and a revelation of future needs which were reflected in the perfection of the plans for the present meeting and of their execution. The reports of the officers and committees contained in the April Journal enabled the members to judge the work already done, and the new policies to be outlined; while the intensive consideration of the reports by the Reference Committees insured an adaptation of the plans to both the immediate needs and their future development.

The unanimous sentiment of the members of the House of Delegates was an appreciation of the constant contact of the State officers and committeemen with the county societies and the individual members. There was almost an entire absence of questioning the wisdom of the activities of the officers and committees, for their contacts with the county societies, close and continuous, had been maintained throughout the year. The monthly reports of the county societies contained in The Journal revealed that the members had given close consideration to the problems as they developed. The criticisms and questioning of the members were expressed in the county societies, and were reported for the benefit of all the members throughout the State. Adjustments of administration and changes in details were made as the necessity became evident, so that the broad outlines of policies were well understood when the delegates assembled in the Annual Meeting. This policy of friendly consideration of all problems by the county societies removed doubt and suspicions, and produced a confidence in the wisdom and broadmindedness of the leaders.

There was no claim for perfection in either the plans or their execution; but there was rather a confidence that perfection will be reached by a slow evolution of existing methods, rather than by a sudden imposition of new plans by any group outside the Society.

A Constructive Prophecy

The medical profession is faced with the necessity of extending the scope of its activities beyond the time-honored duty of giving service to those who seek relief from sickness. The first step in the broadening process has been the rise of the County Medical Society under the leadership of wise prophets in the State Society. These leaders have stated the problem clearly; and the next step must be the active participation of leaders in the county societies in movements adapted to their own localities.

County Medical Societies have been successful in the very necessary field of the scientific education of the individual doctor. They must now enter the field of *administrative medicine*, usually called *economics*, with the implication of over-emphasis on financial relations. But the field is much broader than mere money gain. It involves the education of governmental agencies to participate in the delivery of those forms of medical service which the individuals are unable to secure for themselves from whatever cause.

The most evident point of departure in the development of a broadened field of practice is that along financial lines; and the most acute call is that for a clear statement of the problem, such as that by Dr. Glazebrook in this Journal of March, page 148. The response of

the medical profession was an invitation to the author to expound his principles in greater detail to the Fourth Councilor District, and again to the First. This Dr. Glazebrook has done in the paper which appears on page 207 of this Journal.

Dr. Glazebrook makes no claim for finality in his proposals; but he recognizes the fact that a problem clearly stated is already half solved. He insists that Medical Societies must develop a plan suited to the needs and temperaments of both the physicians and the people of New Jersey; and he has the courage and wisdom to point out a practical solution which has had a profound appeal to those who have heard his address.

Vocations and Avocations

The address of Dr. William Mather Lewis before the Academy of Medicine of Northern New Jersey reported on page 300 of this Journal, expresses the feelings of every physician who is faced with the problem of diverting the thoughts of his patients from their troubles, be they real or imaginary. Every successful practitioner of medicine unconsciously draws the patient out from himself, and arouses his interest in some cultural subject entirely foreign from the stress and strain of business life.

The most difficult of all patients to deal with is the business man whose emotions center entirely in his office work. The wise doctor does not discuss symptoms with his patient; but diverts the sick man's thoughts to external things so that his visit is a benediction to be anticipated with eagerness, and remembered with satisfaction.

The successful doctor exemplifies his own prescription when he takes a vacation, and devotes himself to some avocation in which he is deeply interested.

Success in business depends on doing something one does not like to do, when he does not feel like doing it.

Rest and recreation consists in doing what one likes to do, when he wants to do it.

A college education is health building when it provides a lasting outlet for submerged thoughts and aspirations whose expression is a relief from the emotional stress of earning a living. An avocation is as necessary as a vocation.

Incentives to Action

The psychology teachers of the decades of the sixties and seventies divided mental actions into the *intellect,* the *sensibilities,* and the *will.* This simple classification still applies to the actions of the thinking man today, especially the doctor.

This psychology of the doctor is illustrated in the hearings on the Physicians' Lien Law. Every doctor *knows* that he will benefit by the operation of the law. He develops some degree of *emotion* over it when the newspapers report a series of automobile accidents in his neighborhood. He suddenly develops a *will* to act when he treats the victim of an injury, and receives not even a "thank you" for his services.

Every doctor has read about the Lien Law in the State Journal, and has listened to appeals to attend the court hearing on its final approval; but a common complaint is that the small number of physicians attending the hearing sometimes influences the judge to adjourn the hearing on the grounds that the doctors do not care much about the law.

A committeeman is successful to the degree that he supplies the incentive to action by personally asking a few of his colleagues to demonstrate his interest in a project by coming to a meeting or hearing, and supporting it by his presence and by his voice if necessary.

A real leader supplies the *will to act* as well as to *know* a subject.

Teaching Medical Economics

Medical economics is rapidly becoming a major department of study and practice in every county society. The word "economics" is derived from the Greek *oikos*, house, and *nemos*, management. Medical economics includes all phases of the management of the House of Health. While it was formerly concerned almost wholly with the private affairs of the doctor himself, its scope now includes methods of enabling all classes of people to obtain all forms of medical services, especially those which require special effort, or skill, or equipment.

The economics of medical practice is of mutual concern to every physician and to every citizen. The doctor must receive a proper reward in order to give proper service to his patients without excessive profit. Neither should he be subjected to the insinuation that he neglects his patient because he does not receive an appropriate reward.

Legislation, which might be called *applied economics*, is an essential branch of study in every county medical society. A popular proposal now before the National Congress and the State Legislatures is that the purchase of the services of health be made compulsory by law, with the expectation that the people will utilize their opportunities for health conservation and promotion, and will apply them wisely and efficiently. Education of both the people and physicians will be required in order to guide them wisely through the mazes and pitfalls of the proposed legislation so that an efficient medical service will be assured.

If physicians are prepared to advise the people intelligently regarding the economics of medical practice, the people and their legislators will respond by supporting their plans. This advice must give equal consideration to the point of view of both the doctor and the people.

Closing Schools for Contagious Diseases

When a contagious disease involves school children, the first preventive measure that is usually suggested is to close the school, or at least the classes in which the affected pupils are found. The theory underlying this proposal is that the school is the major source of infection. This may be true when there is no health oversight of the children. But most schools have a system of health inspection by both physicians and nurses.

Moreover, the teachers themselves are observant of their pupils, and are quick to detect the early signs of abnormality,—lassitude, inattention, redness or paleness of the face, red eyes, nose snuffles, hoarseness, or other symptoms of a beginning sickness.

These facts are also to be considered:

1. Children in school are usually better behaved, cleaner, and more orderly than they are anywhere else.

2. They act their normal selves when they are among their companions, and quickly show any departure from their normal activity and behavior.

3. The teacher usually detects a departure from what is normal for each particular child even sooner than the parent.

4. The school nurse is also available to observe suspicious symptoms in every child.

5. The school physician is also available to examine children that are referred to him by the nurse.

6. Children at home are not usually isolated, but are prone to mingle with other children freely.

An effective procedure is as follows:

1. Keep the school or room open, but do not compel attendance.
2. Account for every child every day by:
   - A. A careful observance of every child that comes to school.
   - B. A follow-up of every child that is absent, by:
     - a. Calling the parent on the telephone.
     - b. Visitation at the home by the nurse or school doctor.

C. Make use of the school clerk, or employ extra nurses if necessary.

This system accomplishes two results:

1. It detects the mild and the incipient, and the suspicious cases.

2. It reassures the parents and impresses them with the need of controlling their children outside of school hours.

The system is especially valuable in scarlet fever and measles, for the essential procedure in these conditions is to detect the disease in its incipiency, while the chances of spreading the disease are greatest.

The procedure works almost perfectly in the lower grades, where each pupil is constantly under the observation of one teacher.

It is often ineffective in the upper grades and in the high school because:

a. The pupils go from room to room to recite, and are under several teachers.

b. The older pupils are independent in their actions, and think it "smart" to circumvent "authority".

What may be expected from the system is illustrated by the following example:

In a village with three grammar schools and a high school, five mild cases of scarlet fever were discovered in the lower grades.

The follow-up system resulted in the discovery of fifteen mild, unsuspected cases, within a week after the first cases were found. No more cases developed in the lower grades, but half a dozen developed at intervals among the high school students who were uncoöperative and resented the implication that they might be sick. But this exception really proved the efficiency of the system when it was applied to the lower grades.

Temperaments and Talents

The use which the members of the county medical societies make of their opportunities depends largely upon their individual *temperaments*. Most members are naturally individualistic in their temperament. They must necessarily be so, for they must be original and independent in their dealings with sick patients, each of whom demands the service of his own doctor. The contact of the physician with his patient is of necessity personal and intimate. But every physician feels the need of placing his own talents and knowledge at the disposal of every colleague who requests his aid—which every physician must frequently do.

The first step in leadership consists in defining a need; and then a plan of action is to be clearly outlined. When the leaders of a medical society have taken these two steps, they will search for those members who have the *talents* that are adapted to the particular work which is to be done. Many society activities fail because those members who are assigned to a task do not have the peculiar talents for doing the assigned work, be it speaking, or reporting, or visiting a legislator, or attending a tea of a woman's health organization. The successful leader considers not only the project which he is promoting, but also the temperaments and talents of those who must carry out its details.

The county medical society has a place of service for every member, whatever his temperament or talent may be. It is for the leaders of the society to discover the field of service which appeals to the peculiar temperament and talent of each member. The universal response to that appeal is the glory of the medical profession.

Annals of Medical History

The *Annals of Medical History* published bi-monthly by Paul B. Hoeber, Inc., New York City, is worthy of support by the medical profession. Each issue carries nearly a hundred pages of reading matter, with no advertising. It depends for its existence upon its subscription list, at ten dollars a year, and upon the generosity of its editors and its publisher.

The *Annals* is indispensable for all physicians who wish to learn of the personalities of their great predecessors. The medical achievements of the pioneer doctors were as glorious as those of their modern successors who have the advantages of accumulated scientific lore and research laboratories. It was these medical forebears who established the practice of medicine in its present high standard of ethics and science. The future of the *Annals* depends upon the support which physicians give to their devoted historians.

Leadership

Leadership depends on both the man and the occasion.

Every County Medical Society has its strong members who are capable of leadership should the occasion arise.

The occasion for the exercise of leadership is already here in the form of agitation for sweeping changes in the economics of medical practice.

There are increasing evidences of a constant growth of the spirit of coöperation of physicians with their own leaders. In every meeting of every County Medical Society of New Jersey an appeal is made to the members to participate in the state-wide projects of the Public Health Hour and the Emergency Relief Administration, and to direct the activities of lay health organizations.

The members must solve these and other problems by methods devised by their own leaders, and adapted to the needs of their own communities.

Prescriptions

"This prescription is intended for the person whose name appears hereon and is given for the present indications only; hence it is not to be renewed without my written notice, and no copy of the same is to be given."

"A principle should never be sacrificed to an expediency." (Disraeli.)

The above notice should be printed on each prescription written by a physician, for the protection of the patent, the physician himself, and the pharmacist—and also we might add, the unfortunate ones to whom prescriptions are passed along in the hope that it "might do you some good like it did for me". Cause and effect relationships as seen by patients are rarely reliable. After all, our patients are chiefly interested in getting quick relief. The "quicker the relief, the better the doctor" seems to be an axiom of the lay public.

If a doctor isn't easily available at the time, or the patient feels he himself might save money by self-medication, there is frequently a tendency to use prescriptions which gave him relief in a former illness—or in that of a friend who advises its use on the basis of his own (lay) diagnosis. The suggested protective announcement, if printed on each doctor's prescription blanks, might prove a blessing to all concerned.—L. A. W.

Medical News

Pulling a tooth hurt a dentist in upper Manhattan more than it did the patient. This part of a story in the New York Herald Tribune of April 11 was front page news, describing how a Manhattan patient inhaling an anesthetic threw the dentist out of the window.

The second half of the story telling of the submission of the patient to extraction without gas was an ordinary ending and was printed on the back page of the newspaper, simply as an anticlimax to the first half. However, the story ended in a fine way, with the patient, the dentist, the police, and the newspaper readers all entirely satisfied, each ready to have a tooth pulled if necessary.

ORIGINAL ARTICLES

THE CLASSIFICATION AND TREATMENT OF CHRONIC ARTHRITIS

By John W. Gray, M.D., Newark, N. J.

Read before the Academy of Medicine of Northern New Jersey, January 15, 1935.

There are two great groups of chronic arthritis. The names most widely used among English speaking people are *rheumatoid arthritis* for the first group, and *osteoarthritis* for the second group. Various names are used for these types in different parts of the world. Outstanding clinicians and pathologists have placed a more or less indelible stamp upon the terminology of chronic arthritis as historical references will reveal.

HISTORICAL

Many centuries ago all joint affections were classed as "arthritis". Some 500 years ago the term "rheumatism" was introduced and, as the Greek root of it signifies, it denotes "a humour floating in the blood, causing disease". In 1853 Charcot[1] described chronic arthritis as "primary progressive chronic articular rheumatism". At a later date he classified the senile type as "partial or monarticular chronic rheumatism". About the same time Garrod[2] in England christened the disease "rheumatoid arthritis" and Senator[3] in Germany grouped all chronic arthritis under the name "arthritis deformans". The two types which Charcot differentiated have been recognized under various names by students of the subject since that time. The younger Garrod[4] used the term rheumatoid arthritis for the first type, and osteoarthritis for the second type, and included the juvenile chronic arthritis described by Still[5] in the rheumatoid group.

In America, Goldthwait[6] (1904) gave the names atropic and hypertrophic to Garrod's rheumatoid and osteoarthritis types. Because of the rapid muscle atrophy he considered the atrophic type to be due to a definite but undefined neuropathic factor.

In 1909 Nichols and Richardson[7] published the first careful laboratory study of joint tissues removed by operation and at necropsy. They also recognized two types. In the first type they observed an early proliferation of the synovial membrane, and a small-cell infiltration, with no marked change in the cartilage or bone. Eventually firm bony alkylosis developed. They spoke of this group as the "proliferative or ankylosing type". In their second type there was a tendency to fibrillation or splitting of the cartilage and the development of chrondo-osseous overgrowths. The terminal changes were cartilage degeneration and eburnation of the underlying bone ends without true ankylosis. They spoke of this group as the "degenerative or non-ankylosing type". More than 20 years later, 1931, Allison and Ghormley[8] confirmed in every way the findings of Nichols and Richardson. Their terminology, while accurately descriptive of the early and late pathological lesions, has not been extensively adopted.

Studies in the infectious etiology of arthritis were brought to a climax in 1929 when Cecil, Nichols and Stainsby[9] published the results of their research in rheumatoid arthritis. Cecil suggested that this type should be classified as "chronic infectious arthritis". Our bacteriologic studies[10,11] favor the infectious view, and point toward a streptococcus as the most usual type of infection.

NOMENCLATURE

Terminology seldom keeps pace with investigation; and until there is further corroboration of the more recent research we shall adhere to the nomenclature most universally accepted. The term *rheumatoid* implies that an infectious factor exists; it is a rheumatic-like condition, and rheumatic fever is generally recognized as infectious in origin. There is a close relationship between rheumatic and rheumatoid diseases, and it is frequently difficult to differentiate certain cases of chronic arthritis following rheumatic fever from rheumatoid arthritis. The term *osteo* indicates that this

form of arthritis is essentially a disease of the osteoid structures of the joint.

Rheumatoid is also a convenient term in describing the affection of tissue structures aside from joints when it may be assumed that the underlying etiologic factor is the same—that is, rheumatoid myositis, bursitis, neuritis, fibrositis, iritis, etc. These affections may exist independently in rheumatoid disease; whereas, in osteoarthritis similar complications such as neuritis are due to mechanical pressure.

Some authors regard spondylitis of the rheumatoid or Marie-Strümpell type, usually occurring in young men, as a disease entity, resulting from endocrine dysfunction. Forestier,[12] however, who made an exhaustive study of spondylitis, placed all cases in two groups corresponding to our rheumatoid arthritis and osteoarthritis. In the former he found ligamentous calcification, or "syndesmophytes", which could be detected in x-rays before fusion took place, and the latter group was characterized by the formation of "osteophytes".

It should be understood that rheumatoid arthritis does not include certain minor groups of infectious arthritis such as tuberculous, syphilitic, and chronic gonorrheal arthritis. Nor does it include gouty arthritis which is a metabolic disease.

DIFFERENTIAL DIAGNOSIS

In most respects rheumatoid arthritis and osteoarthritis are quite different. The former usually develops before 50 years of age, while the latter occurs most frequently after that age. The onset of rheumatoid arthritis may be acute, subacute or insidious. The fusiform swelling of the proximal finger joints is almost pathognomonic of this type. Sooner or later if the disease is not checked, many or all of the joints in the body become involved and ankylosis with deformity develops.

The onset of osteoarthritis is always insidious and there is less generalized involvement of the joints than in the rheumatoid type. In mild cases, Heberden's nodes in the terminal finger joints may be the only manifestation of the disease. Of the larger joints the knees are most commonly affected, but ankylosis is slight and never complete.

The clinical picture may be confusing when both types exist at the same time, or when one is superimposed upon the other. Although x-rays show no bony changes early in the course of rheumatoid arthritis, marginal lipping and degeneration typical of osteoarthritis occur not infrequently in the later stages of the disease. Conversely rheumatoid infection may take place in osteoarthritic joints.

The most striking characteristic in the differential diagnosis of these two types of arthritis is the abundant evidence of infection in rheumatoid arthritis and the lack of such evidence in osteoarthritis. In the rheumatoid type the patient is usually undernourished and anaemic, complains of weakness, and gives a history of frequent colds, sinus infection and tonsillitis. In the osteoarthritis type the patient is well nourished, usually overweight and foci of infection are uncommon. In rheumatoid arthritis the sedimentation rate is increased, the hemoglobin is decreased, the immature polynuclear cells may be above normal, the patient's serum usually agglutinates certain strains of streptococci, and by a spceial technic[10, 11] streptococci can be cultured from the blood and the joint fluid in a high percentage of cases. In a small percentage evidence of streptococcal infection is lacking and complement fixation tests may show a relationship of the infection to other organisms.

BACTERIOLOGY

In a series of 200 of my rheumatoid arthritis cases blood cultures were made and streptococci were found in 48 per cent. A much higher percentage of positive cultures was found in the early cases than in the advanced, as shown in table 1. Seventy-nine cases of osteoarthritis were cultured during the same period of time, and all of the cultures were negative for streptococci.

There was also a group of 89 cases of so-called "arthralgia", distinguished from arthritis by the lack of swelling and other evidence of joint pathology, in which 8 per cent showed streptococcal growth. Focal infection was almost as prevalent in this group as in the rheumatoid group, showing that although bacteremia is occasionally associated with focal infection and arthralgia, it is much more com-

mon when the joint infection becomes established. This observation is more or less corroborated by the negative cultures from the joint fluid of my early rheumatoid cases and positive cultures in the more advanced cases.

TABLE 1. BLOOD CULTURES FOR STREPTOCOCCI

	Cases	Cult.	Neg. Cult.	Pos. Cult.	Cases Pos.
Rheumatoid Arthritis					
(Early)	92	137	77	60	65%
(Established)	63	106	83	23	36%
(Advanced)	45	65	53	12	26%
Osteoarthritis	79	95	95	0	0%
Arthralgia	89	108	101	7	8%

A small percentage of staphylococci and diphtheroids also appeared in the cultures. The significance of these organisms could not be determined without further investigation.

Agglutination tests showed high titre readings in rheumatoid arthritis, low readings in osteoarthritis, and moderately high in arthralgia, as shown in table 2.

TABLE 2. AGGLUTINATION TESTS WITH STREPTOCOCCI

	Dilutions of Serum		
	0–80	160–320	640–5120
Rheumatoid Arthritis			
(Early)	24%	17%	59%
(Established)	26%	20%	54%
(Advanced)	30%	17%	53%
Osteoarthritis	83%	17%	0%
Arthralgia	48%	36%	16%

The sedimentation rate indicates activity of a disease process, usually associated with infection. The comparison between rheumatoid and osteoarthritis is shown in table 3.

TABLE 3. CORRECTED SEDIMENTATION RATE

	Millimeters Per Hour		
	0–10	10–20	20+
Rheumatoid Arthritis			
(Early)	23%	37%	40%
(Established)	14%	25%	61%
(Advanced)	8%	25%	67%
Osteoarthritis	85%	13%	2%

PREDISPOSING CAUSES

Thousands of people who have infected tonsils, teeth, sinuses, or other foci, never develop rheumatoid arthritis. The blood is normally bactericidal, and the joint tissues normally resist infection; but if for any reason the joints become susceptible and blood infection exists, the bacteria may gain a foothold in the joint tissues. Among the important predisposing factors are shock, fatigue, trauma, exposure, constitutional infirmity and heredity. A positive blood culture with modern methods of culturing should not be alarming, but it is of significance in tracing the relationship of focal infection, bacteremia and joint infection. The earlier joint symptoms in rheumatoid arthritis may be toxic or allergic, but in a well established case, I believe that there is a localization of infection in the joints.

Endocrine deficiencies may play a part in the etiology of osteoarthritis, but proof of this hypothesis is as difficult as proof of an endocrine origin in arteriosclerosis and hypertension. In a few rheumatoid arthritis cases, I have observed the sudden development of hyperthyroidism and attributed it to the effect of infection, shock and worry. The majority of rheumatoid cases have a diminished metabolic rate associated with the general lowered resistance. There is, however, a group of so-called "menopausal arthritis" cases in which the symptoms promptly disappear when endocrine disturbances are corrected.

INCIDENCE

Not many people realize what a serious medical problem chronic arthritis is until they analyze statistics regarding its incidence. It has been shown that in the state of Massachusetts there are approximately 180,000 cases of chronic rheumatism, which is more cases than of cancer, tuberculosis and heart disease combined.

In this climate approximately 70 per cent of the chronic arthritis patients are of the rheumatoid type and 30 per cent of the osteoarthritic type. I understand that in southern California the figures are reversed. This does not mean that osteoarthritis is more common there than in this climate, but that rheumatoid arthritis is much less common in a southern, warm and dry climate. Hence, in this climate rheumatoid arthritis is the major problem; but the regional difference in incidence is not the whole story. Rheumatoid arthritis affects younger people, is the deformans type, produces innumerable bed-fast cripples and, from the economic standpoint alone is an exceedingly serious problem.

TREATMENT OF OSTEOARTHRITIS

The successful treatment of chronic arthritis depends upon a thorough understanding of the known predisposing and existing causes of both types, and upon the early adoption of individualized, comprehensive and adequately sustained treatment.

In osteoarthritis, if we keep in mind the circulatory, endocrine and metabolic changes taking place at the age of 50, the faulty body mechanics associated with obesity and the effect of trauma, we are in a position to outline a beneficial plan of treatment. Osteoarthritic patients do well in spas, where a basal balance is routinely established, where the mental adjustment to physical limitations is made easy, and where physiotherapy can be intelligently administered.

In private practice a great deal can also be done to relieve symptoms and check the progress of this disease. I shall illustrate this possibility by referring to a case which I treated by common-sense adjustments. The patient was 70 years of age and was rapidly failing in his efforts to continue business duties. After seeing the terrible state of hypertrophy and degeneration which the x-rays revealed in the hip joints, I was surprised that he could walk at all. The feet were badly deformed as a result of untreated fallen arches when young. First the weight was reduced from 210 to 170 pounds. Then he was advised to rest in bed week-ends, lie down at his office one hour in the middle of the day, avoid stairs, use crutches in his apartment and wear a brace for bridging a bad lumbar lordosis. The symptoms of pain and fatigue were relieved, and after 2 years there was no x-ray evidence of further joint damage.

TREATMENT OF RHEUMATOID ARTHRITIS

Rheumatoid arthritis, a chronic infectious disease, requires rest and supportive treatment. The first symptom of joint difficulty must be given serious consideration, and the patient should thoroughly understand the importance of the early adoption of an adequate plan of treatment. Although an initial period of complete rest in bed might be advisable in all cases, there is the economic problem to be considered; and I believe that ambulatory treatment is safe in many mild cases. It must be understood, however, that a great deal of sleep is essential, and that fatigue and exposure must be avoided.

Bed treatment is imperative when many joints are acutely inflammed, or when the knees or other joints of the lower extremities are involved. A febrile, toxic, undernourished patient suffering from acute or subacute polyarthritis may require treatment in bed for a long period of time. Heat, aspirin or codeine are used for the relief of pain. The patient's general condition is most quickly improved by transfusions. Other supportive treatment includes a nutritious diet rich in vitamins, and tonics containing iron and arsenic. There will be less intestinal discomfort if the carbohydrate content of the diet is relatively low.

In a certain percentage of cases the joint symptoms clear up quickly and completely after the removal of infected tonsils or teeth. On the other hand, I have seen the joints made a great deal worse by operating on depleted patients. It is interesting in taking histories to note how frequently severe and permanent arthritis dated from the early radical treatment of focal infection. Sinus infection is one of the most common foci in this disease, and conservative rather than radical treatment is advised. Bacteremia commonly occurs at the time of any operation for the removal of foci. It was found in several of my patients that the blood was sterile immediately before the removal of diseased teeth, and that cultures taken a short time after extractions were positive. It is obvious that if the delicate balance between infection and resistance is very much altered in depleted patients, they will not be able to handle a large shower of bacteria in the blood stream. Hence, the importance of preliminary supportive treatment, and of gentle handling of tissue by the operator.

While treatment is being carried out for building up the patient's resistance and for controlling the infection, special treatment will be necessary for preserving the joint function and muscle tone. As soon as the more acute joint symptoms subside, mild exercises and massage should be started in order to prevent joint adhesions, flexion contracture, ankylosis and muscle atrophy. Splints and casts so

constructed that they can be removed daily for exercise and massage will relieve muscle spasm and tend to prevent contracture. Such appliances are particularly useful in preventing and correcting flexion of the knee joints. In cases of rheumatoid spondylitis where more or less fusion always takes place, early rest, proper support, and appropriate exercises are essential for maintaining an erect posture and joint mobility.

In both mild and severe early cases cultures of foci, the blood and joint fluid are made in an effort to obtain specific bacteria for vaccine purposes. Agglutination tests and complement fixation tests are of value in this connection. Wood, Jensen and Post[13] recently reported the results of their electrophoresis studies, and showed that this method is useful in detecting reactions between antibodies and homologous bacteria.

It has been shown that immunity can be established in animals by the injection of bacteria and their products. Several years of experience has convinced me that suitable vaccine is beneficial in the treatment of rheumatoid arthritis. The most convincing proof of its value comes from the treatment of patients in an out-patient department where other forms of treatment were essentially impossible.

Vaccine may be administered subcutaneously or intravenously. I prefer the intravenous method in the early and more acute phase of the disease because of its desensitizing effect.

The dose of a *specific* vaccine should never be large, never large enough to produce much reaction, and should be continued over a long period of time. This type of vaccine therapy should not be confused with *non-specific* vaccine therapy where fever and temporary leucocytosis are produced by large doses. Similar reactions with specific vaccine tend to create a negative phase and do more harm than good.

I have found that some patients who react unfavorably to minute doses of vaccine are low in complement. The complement may be built up by the use of various tonic measures such as transfusions, ultra-violet treatment and a high vitamin diet.

During convalescence the patient requires a modified continuation of the "rest cure", supportive treatment and exercises. The sedimentation rate approaches normal as improvement takes place. Until the infection is controlled there is always danger of recurrence. The danger of reinfection from recurrent upper respiratory infection may be minimized by transporting the patient to a warm, dry climate during the winter months.

The *advanced cases* are a greater problem. As a rule they have run the gantlet of casual treatment or neglect, and have lost hope ,and morale. Many are unable to walk because of weakness and muscle atrophy. Transfusions may give such patients a real start. Because of a general lack of tone the gastro-intestinal tract requires more careful attention than in the earlier cases.

Some patients try to shuffle around while their knees are in a state of flexion contracture. One of the first "don'ts" is not to walk until the knees are straightened. This can frequently be accomplished by the use of serial removable casts. When the knees are straight a walker will be useful for the cautious application of weight bearing.

I have been surprised to find that many advanced cases still harbor foci of infection. In "burned out" bed-ridden cases, however, it is obvious that little, if anything, is to be gained by removing tonsils or by administering vaccine.

During the past year I was very much impressed with the results of treatment in an advanced case which at first sight seemed hopeless. The patient was 68 years of age and had suffered from polyarthritis for 8 years. The knees were persistently involved from the beginning, and had become locked in a position of marked flexion. There was great loss of weight, poor digestion and elimination, and the patient was more or less resigned to invalidism.

After three months of hospitalization the knees were straightened by removable casts. Every possible supportive measure was employed, including transfusions. It was a long time before the gastro-intestinal tract was straightened out so that food could be normally assimilated. Progressive exercises had to be skillfully managed. As time went on

it was observed that various joints intermittently flared up. This was finally attributed to the presence of diseased teeth. They were extracted and cultured, and a vaccine was prepared from the streptococci isolated from their pulps. The patient left the hospital after three months and treatment was continued at home. A special table was constructed for exercises, and a walker was built for practicing the "motions" of walking. After 6 months of treatment at home the patient walked without assistance and had gained 25 pounds in weight.

The American Committee for the Control of Rheumatism has shown that highly favorable results should be obtained in at least 70 per cent of all cases. This cannot be accomplished without more adequate institutional facilities than this country now has for the rehabilitation treatment of the more advanced cases. When such institutions are established, and when patients and the profession pay more attention to early treatment, there will be fewer arthritic derelicts.

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THE VALUE OF METAPHEN IN THE TREATMENT OF GENITO-URINARY INFECTIONS

Charles H. de T. Shivers, M.D., F.A.C.S., Atlantic City, N. J.
Associate Professor of Urology, University of Pennsylvania, Graduate School of Medicine: Chief of Urological Department, Atlantic City Hospital and Atlantic City Genito-Urinary Clinic.

and

Charles J. Cooney, M.D., Fort Wayne, Indiana
Formerly First Assistant in the Department of Urology, Atlantic City Hospital, Atlantic City, New Jersey

From the Urological Department of the Atlantic City Hospital

SUMMARY

This paper describes the results of the use of metaphen in solutions of 1-30,000 to 1-5,000, as local applications in a series of cases of infections of the genito-urinary tract. The infections varied from those of acute and chronic Neisserian, to colon bacilli involvement of the bladder and upper tract. Excellent results were attained in all types of cases.

Metaphen is an organic mercury compound discovered by Dr. George W. Raiziss and designated chemically as 4-nitroanhydro-hydroxy-mercuri-ortho-cresol.

The superior germicidal properties of Metaphen have already been noted in the literature on many occasions. The very first papers[1, 2] reporting the discovery of this drug contained impressive figures regarding its bactericidal action. It was found to be bactericidal for gonococci in adilution of 1 to 380,000 in a 15 minute exposure, for the pneumococ-

cus in a dilution of 1 to 55,000 in 1 hour exposure, for B. Anthracis 1 to 326,000 in 1 hour exposure, etc. In an exposure of 24 hours the growth of staphylococcus aureus is inhibited in a dilution of 1 to 20,400,000. Figures of the same order of magnitude were obtained in a recent investigation of Konrad E. Birkhaug[3, 4]. Correspondingly gratifying results have been reported concerning the clinical use of metaphen in a variety of fields, viz., surgery[5, 6, 7], obstetrics[8], otolaryngology[9] and urology[10].

Supplementing the aqueous and alcohol-acetone solutions of metaphen, a most interesting development is the preparation known as "metaphen in oil". This is an oil-soluble form of metaphen, the vehicle being vegetable oil. Bactericidal tests have shown that metaphen in oil kills gonococci in one minute exposure in a dilution of 1 to 200,000. In 50 per cent serum, metaphen in oil destroyed staphylococcus aureus in a dilution of 1 to 5,000 in one minute exposure[11]. Recently it was found that metaphen in oil is bactericidal for B. coli in a dilution of 1 to 80,000 in one hour exposure[12].

In addition, the toxicity of this preparation is comparatively low. Upon oral administration, rabbits tolerate 150 cc. of the 1 to 5,000 solution per kilo of body weight[11]. Confirming these laboratory findings, its successful use has been reported in the treatment of wounds, compound fractures, empyema, bronchiectasis and pulmonary cavitation[13, 14] and also in gynecological infections.

Kolmer and Harkins,[15] in an article published in 1931, showed conclusively the value of "aqueous metaphen as a disinfectant, with special reference to the skin, in strengths ranging from 1:500 to 1:2,500. For a number of years it has been our custom to use metaphen about our operative wounds. In infected cases, where drainage is required, the gauze is saturated with 1:500 aqueous solution. The rapidity of clinical improvement in many cases has been remarkable. Following suprapubic cystotomy and various renal operations, especially perinephritic abscess, it is an excellent way of keeping the wound clean. There has been no toxic effect from the use of metaphen, even where the gauze drain is introduced deep into the wound and saturated with the solution.

We have used metaphen in the treatment of acute and chronic Neisserian infections and also in the colon bacillus and other infections of the bladder and upper urinary tract with very gratifying results. The dilutions we have employed are 1:30,000 in aqueous solution and 1:5,000 in the oil solution and the drug is well tolerated and effective when used in the urethra, bladder, or kidney pelvis in these dilutions.

The presence of menthol in the oil solution has a cooling effect on the urethral mucosa and the average patient complains of absolutely no urethral irritation following its use. There is only occasional slight vesical irritation after the aqueous solution 1:30,000 is used for bladder irrigation. This latter, of course, depends to a considerable degree upon the character and extent of the bladder infection.

ACUTE INFECTIONS OF THE URETHRA

Most of the cases of urethritis in this series were due to the gonococcus, although a few cases of non-specific infection are included (see table 1 and 2). The great majority of these cases responded well to treatment, especially those who were careful in carrying out the instructions in regard to home treatment.

The two glass test of urine was used to show the character and extent of the urethral involvement; and urethral smears were taken daily, using the Gram stain and counting the number of infected cells per high power field. Also the subjective and objective symptoms of the patient were recorded daily.

The treatment employed in our cases is varied somewhat to suit special conditions, but in the main it consists of a preliminary anterior urethral irrigation with warm aqueous metaphen solution 1:30,000 followed by the injection, into the anterior urethra only, of about one half dram of metaphen in oil 1:5,000. The meatus is then held by the patient and the oil retained in the urethra for five minutes. The patient always voids before this treatment, of course. The preliminary irrigation

TABLE 1.—METAPHEN IN AQUEOUS SOLUTION, 1-30,000

Case Number	Age, Years	Day of Disease when Treatment Was Started	Anterior Urethritis	Anterior and Posterior Urethritis	Number Infected Cells per H.P. Field 1st Smear	2nd Smear	Number of Days to Free Smears from Gonococci	Number of Days to Stop Urethral Discharge	Number of Treatments Given	Complications
1[1]	28	3	+	+	4	1	3	5	30	+
2	26	3	±	+	2	1	8	14	25	+
6[2]	22	10	+	+	0	0	0	1	4	0
15[3]	38	1	+		5	0	1	1	5	+
29	29	3		+	3	1	3	3	12	0
30	21	30		+	5	3	39	42	30	+
31	32	9	+		2	0	4	4	20	0
32	45	8	+	+	3	0	7	7	7	0
33[4]	24	2	+	+	1	0	1	9	21	+
37	24	7		+	0	0	0	4	18	0
38	28	2	+		0	1/10	2	3	3	0
42	27	1	+	+	2	0	1	3	3	0
45[5]	42	2		+	0	3/10			4	0
46	21	2		+	2	3	5	6	19	+
48[7]	19	4		+	3	3			4	0
49	36	3		+	1	0	1	3	3	0
50[8]	22	7	+		0	1	28	34	96	+
51	24	7	1	+	3	2	30	58	28	+
52	32	5	+		2	6	14	19	11	+
53[9]	42	10	+	+	0	0	0	1	2	0
55[10]	32	19		+	3	3/10	26	39	69	+
60[11]	28	1	+	+	0	4/10	4	4	4	0
63[12]	23	3		+	1		1	3	15	+
64[13]	21	5		+	1		1	1	2	0
66[14]	35	2		+	4	3/10			6	0
67[15]	35	14		+	2	0	1	2	4	0
68	22	3	+		3	1/10	1	2	10	+
71[16]	23	2	+		0	0	0	8	5	0
73[17]	27	3	+		3	0	1	13	18	+
74[18]	32	2	+		3	1	12	17	32	+
76	43	3		+	3	1	7	30	22	0
78[19]	17	3	+		4	2			5	0
79	59	2		+	3	0	1	5	6	0
81[20]	24	7		+	4	3			2	0
83	58	5		+	2	2	6	8	13	0

1. Balano-posthitis when treatment was started.
2. Case of non-specific urethritis.
3. Prostatitis one month later due to alcoholic and sexual excess.
4. Recurrence of discharge on 27th day due to heavy drinking.
5. Patient did not return after fourth treatment.
7. Discharge improved but had not entirely disappeared after fourth treatment when patient discontinued treatment.

8. Recurrence of discharge on 52nd day due to prostatitis.
9. Non-specific urethritis.
10. On 20th day early symptoms of G. C. arthritis of phalangeal joints of right hand and also arthritis of right knee joint developed. Attack was aborted by daily intravenous injections of Salihexin gr. 15½.
11. Did not return after fourth treatment.
12. Acute right epididymitis at the time patient presented himself for treatment.
13. Did not return after 2nd treatment.
14. Patient did not return after 6th treatment. The discharge was still present with first urine hazy and second urine clear.
15. Did not return after sixth treatment.
16. Non-specific urethritis.
17. Prostatitis required prolonged course of massage after urethritis was cured.
18. Right seminal vesiculitis on eighth day. Right epididymitis on 130th day.
19. Treatment changed to silver nitrate 1:20,000 on tenth day because of unsatisfactory progress on Metaphen in Oil.
20. Did not return after two treatments.

helps to destroy organisms, but its main purpose is to cleanse the urethra of the plugs of mucous in the opening of the urethral glands. The metaphen in oil, because of its marked bactericidal power and affinity for cocci, combined with its penetrability and non-irritating properties, forms a highly satisfactory drug for injection following the irrigation with aqueous metaphen.

TABLE 2.

AQUEOUS SOLUTION OF METAPHEN 1:30,000 FOLLOWED BY METAPHEN IN OIL 1:5000

ACUTE GONORRHEAL URETHRITIS

Case Number	17	84
Age—Years	29	25
Day of Disease when Treatment Was Started	3	2
Anterior Urethritis	+	+
Anterior and Posterior Urethritis	+	+
Number of Infected Cells per H.P. Field (1st Smear)	2	1
Number of Infected Cells per H.P. Field (2nd Smear)	4	2 in 10 H.P.F.
Number of Days to Stop Urethral Discharge	5	13
Number of Days to Free Smears of Gonococci	6	27
Number of Treatments Given	13	17
Strength of Solution	1-30,000	1-30,000
Strength of Solution	1-5000	1-5000
Complications	0	0

Examination of the prostate gland and seminal vesicles was not made in acute cases until the discharge was stopped and the urines clear, with negative subjective symptoms. At this time the urethra was also examined for stricture and if any obstruction was found it was treated accordingly.

Many of these cases discontinued treatment after the discharge stopped and we were unable to follow them to determine the ultimate result.

Thirty-six cases of acute urethritis were studied, the average number of days required to render the discharge gonococcus free being seven. The minimum number of days was one and the maximum number thirty-nine. In this case requiring thirty-nine days, the patient developed epididymitis on the fourth day, due to sexual excitement; and in most of the instances of delay in disappearance of the organisms from the urethral discharge there was a similar story of indiscretion on the part of the patient.

The discharge was stopped in an average of ten days in our acute cases although there were several in which no further discharge was seen after the first or second injection of metaphen in oil. In this series, as in most similar tables, the occurrence of two or three refractory cases, requiring prolonged treatment, materially increased the number of days averaged for stopping the discharge in the series as a whole.

Of the thirty-six cases of acute gonorrheal urethritis studied, only one failed to improve on metaphen in oil. This patient, however, made unsatisfactory progress on other drugs which were substituted and had a very prolonged course of treatment before finally recovering.

Acute posterior urethritis and involvement of the prostate gland were the most frequent complications, and were usually caused by alcoholic or sexual excesses on the part of the patient, in spite of our warnings. Epididymitis was next most frequent and was due to the same causes. One case developed gonorrheal arthritis on the twentieth day after treatment was started, but the attack was aborted by stopping all local treatment, instituting appropriate general measures, and giving Salihexin 15½ grains intravenously daily, as mentioned in the footnotes.

TABLE 3.
METAPHEN IN OIL
CHRONIC GONORRHEA WITH ACUTE EXACERBATION OF URETHRITIS

Case Number	7	261	27	58	62	772	105	86
Age, Years	25	23	37	35	21	31	40	21
Previous Attacks	2	2	2	1	2	4		0
Duration of Present Attacks (Days)	16	14	4 Mo.	2	21	3 Wks.	28	7
Extent of Involvement: a. Anterior Urethritis	+	+	+	+		+		
b. Anterior and Posterior Urethritis	+	+			+		+	+
c. Prostatitis	+	+	+	+	+		+	+
d. Seminal Vesiculitis			+					
Number of Infected Cells per H.P. Field (1st Smear)	2 in 10 H.P.F.	0	0	1 in 10 H.P.F.	3 in 10 H.P.F.	0	3	1
Number of Infected Cells per H.P. Field (2nd Smear)	1 in 6 H.P.F.	0	0	0	0	0	0	1 in 10 H.P.F.
Number of Days to Free Smear of Gonococci	3	0	0	2	1	0	30	10
Number of Days to Stop Urethral Discharge	6	1	1	5	5	5	45	12
Total Number of Treatments	20	24	4	11	7	4	27	9
Strength of Solution	1/5000	1/5000	1/5000	1/5000	1/5000	1/5000	1/5000	1/5000
Complications	0	0	0	0	0	0	+	0

1. Patient had cloudy urine (1 and 2) but no urethral discharge.
2. Urethritis due to mixed infection. No gonococci found in repeated smears.
3. Multiple recurrences due to alcoholic and sexual excesses.

ACUTE EXACERBATIONS OF CHRONIC URETHRITIS

In the acute exacerbations of chronic gonorrhea, the treatment employed was the same as in the acute cases (see table 3). However, these patients showed a decided tendency to more rapid subsidence of the urethritis than cases of new infection.

The average number of days required to render the discharge gonococcus-free in this group was three days, which was less than half the average tim erequired in the cases of new infections. The average number of days required to stop the urethral discharge, however, was ten, which is the same as the average time for acute infections. No case failed to improve in this group and there were no complications. One case only required prolonged treatment (30 days) before the discharge was rendered gonococcus-free but this case had multiple recurrences due to frequent sexual and alcoholic digressions.

Treatment of the prostate and seminal vesicles was started in these cases as soon as the acute urethritis cleared up, as of course these exacerbations are invariably due to re-infection of the urethra from a flare-up of a chronically infected prostate or seminal vesicle. The anterior urethra was always examined to determine the presence or absence of strictures.

Our usual method of treating these infections of the prostate and seminal vesicles consists in gentle but thorough massage over a partially filled bladder twice weekly; the patient is then instructed to void, following which one-half dram of metaphen in oil is injected into the anterior urethra. This is re-

TABLE 4.

Case Number	Age, Years	Previous Attacks	Duration of Present Attack	Anterior Urethritis	Posterior and Anterior Urethritis	Prostatitis	Seminal Vesiculitis	Number of Infected Cells per H.P. Field 1st Smear	2nd Smear	Treatments Given to Stop Urethral Discharge	Complications
3	22	1	9 M	+	+	+	+	0	0	24	0
4	19	0	5 M	+		+	0	0	0	1	0
5	32	1	2 M		+	+		3/10	0	12	0
8	25	0	6 M	+	+	+		0	0	1	0
13	37	1	8 D	+		+		0	0	4	0
18	34	1	5 M	+		+	+	1/10	0	1	0
19	30	2	5 M	+		+		2/10	1/10	26	0
34[1]	24	1	3 W	+				1/10	0	5	0
35	25	1	1 D	+		+		2/10	0	3	0
36[1]	22	0	7 M		+	+		1/10	3/10		0
39[2]	26	1	1 M	+				0	0	3	0
41[3]	26	0	4 M		+	+		3/10	0	4	0
44	65	0	2 W	+		+		0	2/10	46	+
47	45	1	Sev. M		+	+	+	0	0	Hazy	0
57	40	6	6 D	+		+	+	1/10	4/10	3	0
61[5]	37	0	5½ M	+	+	+	+	3/10	0	22	+
65	36	2	3 W	+	+	+	+	1/10	0	41	0
70	27	1	7 M	+	+	+		0	0	4	0
72	18	0	3 W	+		+		0	0	4	0
77	24	1	2 Y		+	+		1	0	3	0
80	21	1	2 W	+		+		0	0	7	0
82	28	2	1 W		+	+	+	0	0	7	0

1. Discharge still present and both urines hazy after 12 treatments, when patient returned to his home city.
2. This discharge appeared 5 months after discontinuing treatment for chronic G. C. prostatitis. Three treatments stopped the discharge; no further recurrences.
3. Involvement of periurethral glands in fossa navicularis on the 16th day of treatment.
4. Patient did not return after 6 treatments. Both urines remained hazy at that time.
5. Left epididymitis 21 days after treatment was started.
6. Patient had chronic right epididymitis when he presented himself for treatment.

tained for five minutes by the patient holding the urethral meatus between thumb, index and second finger. Only in exceptional cases do we medicate the deep urethra and we have found that by discontinuing treatment to the deep urethra, our incidence of complications has been greatly lessened.

The instillator is a dangerous instrument because of the trauma it may produce unless carefully and skillfully introduced. Total irrigations of the urethra are also dangerous because of the pressure which must be used, in many cases, to over-come the resistance of the cut-off muscle and the consequent trauma produced.

We limit the cases which are given posterior treatment to those that fail to improve after a fair trial of massage of the prostate and seminal vesicles, and treatment of the anterior urethra. In such cases through and through irrigations are very carefully given, using a B-D blunt-tipped bulb glass syringe. We discarded the gravity irrigator for this work several years ago, as we feel that produces too much intra-urethral pressure, thus inviting epididymitis and other complications.

TABLE 5.
AQUEOUS SOLUTION OF METAPHEN 1:30,000
KIDNEY AND BLADDER INFECTIONS

Age, Years	66	51	52	62	25	11	79	59
Case Number	20	21	22[1]	85[2]	87[3]	88[4]	115[5]	256[6]
Previous Attacks	Many	0	0	0	0	0	4	0
Duration of Present Attack	3 Mo.	2 Wks.	1 Yr.	1 Wk.	5 Days	Since Birth	4 Mo.	6 Mo.
Extent of Involvement: a. Pyelitis; cystitis								
b. Pyelonephritis; cystitis	+	+		+	+	+	+	+
c. Hydronephrosis with Infection and Cystitis			+					
Causative Organism: a. Smear	B. Coli		B. Coli	B. Coli	B.Coli	B. Coli	B.Coli	B. Coli
b. Culture	B.Coli	Staphylococcus Aureus	B. Coli	B. Coli	B.Coli	B. Coli	B.Coli	B. Coli
Number of Treatments Given: a. For Macroscopically Clear Urine	20	25	21	3	13	After Operation 14		After Operation 21
b. For Microscopically Negative Urine	23	28		4	26	18		28
c. For Negative Smears	26	30		8	27	18		30
d. For Negative Cultures	**26**	**30**		**8**	**27**	**18**		**30**
Clinical Improvement	+	+	+	+	+	+	+	+

1. Multiple urethral strictures and chronic prostatitis.
2. Previous to use of aqueous metaphen patient received five bladder irrigations of silver nitrate 1:20.000 with no improvement.
3. Pyeloureterogram showed duplication of the kidney pelvis with union of the ureters on this side at the level of the fourth lumbar vertebra.
4. Pathology in this case due to congenital malformation of the external urinary meatus which presented an hypospadias, with a pin-point opening in the floor of the urethra through which the urine escaped. This pin-point opening was located about ½ cm. posterior to the normal location of the meatus. The bladder contained a phosphatic calculus.
5. Patient had a permanent suprapubic urinary fistula resulting from a prostatectomy performed in another city. In addition, there was a fairly large diverticulum of the bladder which was chronically infected and rendered it impossible to clear up the urine.
6. Obstruction of the bladder outlet due to a large median prostatic lobe accounts for the failure of aqueous metaphen to entirely clear up the bladder infection in this case. A transurethral prostatic resection was subsequently done.

INFECTIONS, CHRONIC AND COMPLICATED

In the last or chronic group there were twenty-two cases, every one of which had infection of the prostate gland and in seven there was clinical evidence of involvement of one or both seminal vesicles. All but six had some degree of infection of the anterior urethra (see table 4).

We feel that the importance of a careful examination of these chronic cases, to determine the part of the urinary tract involved and the extent of the involvement, is something that cannot be over-emphasized. The treatment, of course is based upon the location and extent of the chronic infection but in the main is the same as for the acute urethral infections or acute exacerbations, with massage of the prostate and seminal vesicles as soon as the urethral infection is well controlled.

The minimum number of days required to render the discharge gonococcus-free in this group was one. The maximum time was forty-six days, but in this case the urethritis was maintained by an infection of the peri-urethral glands in the fossa novicularis. The average number of days required to render the discharge gonococcus-free was one and one-half, which is of course much sooner than the average in the acute cases and also the cases of acute exacerbation of urethritis. The discharge was stopped in this group in an average of eleven days and no case was encountered which failed to clear up on metaphen in oil. The average number of treatments given

TABLE 6.
METAPHEN IN OIL 1:5000
BLADDER INFECTIONS

Case Number	91	232	243	28	404	565	696	757
Age	39	50	60	38	22	82	52	48
Previous Attacks	1	0	0	0	1	Many	0	1
Duration of Present Attack	4 Wks.	6 Yrs.	3 Days	2 Days	2 Days	45 Days	2 Wks.	2 Days
Extent of Involvement:								
a. Localized Bladder Infection				+			+	
b. Generalized Bladder Infection	+	+	+		+	+		+
Causative Organism:								
a. Smear	B. Coli	B. Coli	B. Coli	B. Coli	B.Coli	B. Coli	B.Coli	B. Coli
b. Culture	B. Coli	B. Coli	B. Coli	B. Coli	B.Coli	B. Coli	B.Coli	B. Coli
Total Number of Treatments Given	2	35	27	17	11	37	23	18
Number of Treatments Given:					After Operation			
a. For Macroscopically Clear Urine	1			7	18	34	5	8
b. For Microscopically Negative Urine				12	22			
c. To Obtain Negative Smears				13	30			
d. To Obtain Negative Cultures				13	30			
Clinical Improvement	+	+	+	+	+	+	+	+

1. Patient returned to her home city after two treatments. Marked clinical and laboratory improvement, but urine still contained pus cells.
2. Failure of injection to entirely clear up due to atonic type of bladder, without nerve involvement, and a long standing colon bacillus infection.
3. Tabetic bladder complicated by diabetes.
4. Persistence of infection due to vesicle calculus after operation cleared up.
5. Patient had chronic prostatitis of 25 years' duration. Urine improved markedly more than with any treatment he had ever received and all clinical symptoms of bladder infection disappeared.
6. Urine still contained a few pus cells after 23 treatments but all clinical symptoms were relieved.
7. Patient did not return after 18 treatments. Marked improvement, both clinical and laboratory.

Due to lack of co-operation on the part of some of the patients who did not return for microscopic examination of urine, data are incomplete.

was eleven. The time necessary to cure the infections of the prostate and seminal vesicles or to dilate urethral strictures, etc., is not included in this article. Two cases in this group developed complications while under treatment. In No. 44, involvement of the periurethral glands on the 16th day of treatment, and in No. 61, left epididymitis 21 days after treatment was started.

BLADDER AND UPPER URINARY TRACT INFECTIONS

The cases of cystitis treated in our series were mainly secondary to kidney infections or associated with mechanical obstruction at the bladder neck or in the urethra. The colon bacillus was the predominating organism in all the cases and in only a few, principally female, was the infection confined to the bladder alone (see tables 5, 6, 7).

It was necessary, of course, in all cases of kidney infection showing obstruction in some portion of the lower urinary tract, to correct the condition responsible for the bladder infection before any decided improvement was noted. However, in some instances there was a very marked decrease in the vesicle irritability after the first or second treatment, and before any attempt was made to remove the underlying cause of the bladder condition.

In treating cystitis, we routinely take a catheterized specimen of urine for chemical and microscopic examination and also stains. This is repeated at the time of each treatment

TABLE 7.

METAPHEN IN OIL 1:5000

KIDNEY AND BLADDER INFECTIONS

Case Number	16	43[1]	54[2]	59[4]	89
Age	30	38	42	41	74
Previous Attacks	0	0	0	0	0
Duration of Present Attack	5 Days	20 Mos.	1 Yr.	20 Yrs.	4 Wks.
Extent of Involvement:					
a. Pyelitis					
b. Pyelonephritis	+	+	+		+
c. Hydronephrosis with Infection			+	+	
Type of Infection:					
a. Culture	B. Coli	B. Coli	B. Coli	B. Coli	B. Coli
b. Smear	B. Coli	B. Coli	B. Coli	B. Coli	B. Coli
Number of Treatments Given for:					
a. Macroscopically Clear Urine	6	1			2
b. Microscopically Negative Urine	16	7			11
c. Negative Smears	27	7			11
d. Negative Cultures	27	7			11
Clinical Improvement	+	+	+	+	+

1. Chronic cystitis.
2. Bilateral ureteral calculi; removal cured the infection.
4. Chronic bilateral hydronephrosis; infection had existed for many years. Patient did not return after 3 kidney treatments.

Due to lack of co-operation on the part of some of the patients who did not return for microscopic examination of urine, data are incomplete.

TABLE 8.

SYNOPSIS OF RESULTS OBTAINED IN THE TREATMENT OF GONOCOCCAL URETHRITIS WITH METAPHEN IN OIL

	Acute	Acute Exacerbations	Chronic	Aqueous Metaphen Plus Metaphen in Oil
Number of Cases Studied—66	36	8	22	2
Minimum No. of Days Required to Render Discharge Gonococcus-free	1	1	1	5
Maximum No. of Days Required to Render Discharge Gonococcus-free	39	30	46	13
Average No. of Days Required to Render Discharge Gonococcus-free	7	3	1½	9
Average No. of Days Required to Stop Urethral Discharge	11	10	11	16½
No. of Cases Failing to Improve	1	0	0	0
No. of Cases in Which Complications Developed After Treatment Was Started	55 68 20 6 74 89 51	0	34 39 4 44 61	0
Average No. of Treatments Given by Physician	16	11	11	15

Note: The column on the right, which is a synopsis of the two cases treated with Aqueous Metaphen 1:30,000 followed by Metaphen in Oil held in the anterior urethra for five minutes, should be read separately from the first three columns. It is only placed in this position to facilitate comparison with the synopsis on Metaphen in Oil.

and thus an accurate check can be made of the patient's progress.

It is our practice to treat the bladder daily until there is decided improvement, when the treatments are given at gradually lengthening intervals. Later ureteral catheterization is done and the urine from the kidneys is examined chemically, microscopically and by stains and cultures.

The local treatment, of course, are supplemented by forcing of fluids, urinary antiseptics by mouth or intravenously, Dietary regulation and general hygienic measures.

When aqueous metphen is employed in the treatment of cystitis, we use one quart of solution, 1:30,000 strength, for each irrigation; and one or two ounces are injected at a time, using a bulb glass syringe and soft rubber catheter. The results obtained have been excellent and the solution causes no vesica lirritation, except in hyperacute infections.

PROSTATECTOMY

Another very important field of usefulness for the aqueous metaphen solution is in the preoperative and postoperative treatment of cases for one or two stage prostatectomy.

We find that these cases come to operation in much better condition when the catheter drainage etc., is supplemented by thorough bladder irrigations, once or twice daily, using one quart of the aqueous metaphen solution, 1:20,000 to 1:30,000 strength. The bladder infections are cleaned up much more effectively than when we used silver nitrate, potassium permanganate or acri-flavine. Aqueous metaphen solution is also used in distending the bladder for all suprapubic cystotomies.

Postoperatively, after the first stage beginning usually on the fourth or fifth day, the bladder is gently irrigated daily with one or two quarts of the same solution using a bulb syringe and only injecting one-half to one ounce of solution through the de Pezzar tube at a time and allowing all of the fluid to return before another injection is made. This obviates the danger of extravasation of the fluid through the suture line or about the suprapubic tube. We find that the urine soon becomes clear and if there is no upper urinary tract infection, it remains clear until the second stage operation is performed. Following removal of the prostate we leave a Pilcher bag in the prostatic cavity for 48 hours and upon its removal a No. 18 or No. 20 French soft rubber catheter is fixed in position for continuous bladder drainage. We then irrigate the bladder gently two or three times a day, using warm 1:30,000 metaphen solution and injecting one-half to one ounce at a time. As the suprapubic sinus begins to close, even this small amount is injected slowly and with great care, to prevent pressure against the healing sinus.

We find that since introducing the above régimé, our bladder infections are cleared up much more quickly and our morbidity in prostatectomy is reduced materially.

When using metaphen in oil, the bladder is emptied, one ounce of the oil injected and the catheter withdrawn. The oil is allowed to remain in the bladder until the next urination and almost never causes discomfort. There is some added advantage of prolonged action of the drug here, as the oil clings quite tenaciously to the bladder mucous membrane. We have seen countless oil globules in a patient's urine weeks after a single bladder treatment.

BLADDER AND KIDNEY INFECTIONS

Metaphen in oil is very effective in most types of cystitis; but in bladder tuberculosis our results did not prove superior to those obtained by other methods of treatment.

We do not recommend metaphen in oil for the treatment of kidney infections, although we have injected it into the renal pelvis in several cases with no untoward symptoms resulting. However, because of the possibility of oil embolus, and also because the oily solution adheres to the mucosa of the ureter, interfering with drainage and sometimes causing symptoms similar to those produced by the passage of blood clots, we feel that the aqueous solution of metaphen is much superior for this purpose.

In the table on bladder infections treated with metaphen in oil, eight cases are listed. A great many more were treated with this drug but discontinued treatment after a few visits

and their data was not included for this reason. All of the cases showed marked clinical improvement; in one case (No. 9) there was temporary bladder irritation, lasting three or four hours after the first treatment and then almost complete disappearance of the frequency, dysuria and terminal tenesmus from which she had been suffering for four weeks, despite frequent bladder irrigations with a variety of drugs.

Case 56 in the table (VI) on bladder infections treated with metaphen in oil, was a man 82 years of age who had a chronically infected prostate with some hypertrophy and cystitis of 25 years duration.

He carried about two ounces of residual urine. When he first consulted us he was suffering from an acute exacerbation of his cystitis. There was frequency, dysuria and nocturia and the patient was extremely uncomfortable.

Microscopic examination showed the urine to be loaded with pus cells and motile bacilli, presumably colon.

Treatment was instituted consisting of gentle prostatic massage twice weekly and daily bladder irrigations, using acriflavine solution 1:16,000. As no improvement was noted after several treatments, boric acid was substituted in the hope of allaying the severe vesical irritability. This, however, proved even less successful than the acriflavine. Therefore, about two weeks after treatment had been first started it was decided to try metaphen in oil. The treatment was given in the same manner as when the other drugs had been used, except that one ounce of metaphen in oil 1:5000 was injected and the catheter was withdrawn. The result was striking indeed. The vesical irritation and frequency, which had increased rather than decreased upon two weeks' treatment, almost completely subsided overnight; and although he experienced slight bladder discomfort immediately after injection of the oil, his symptoms had entirely disappeared after four treatments. This patient stated that he had had almost every known drug used during the past twenty-five years but none compared with metaphen in oil in relieving his bladder symptoms.

Table VIII represents a synopsis of results obtained in the treatment of gonococcal urethritis with metaphen in oil.

CONCLUSIONS

1. Metaphen is an organic mercury compound possessing superior germicidal properties.

2. It was used in aqueous solution of 1:30,000 and in oil in a concentration of 1:5000 in the treatment of acute and chronic Neisserian infection and also in colon bacillus and other infections of the bladder and upper urinary tract with gratifying results.

3. The majortiy of the cases of urethritis were due to the gonococcus and responded well to treatment.

4. The metaphen in oil, because of its marked bactericidal power and affinity for cocci, combined with its penetrability and non-irritating properties, forms a highly satisfactory drug for infection following the irrigation with aqueous solution.

5. The average number of days to free the discharge of gonococci in acute urethritis was seven.

6. In the acute cases the discharge usually disappeared in an average of ten days. In several cases it disappeared after the first or second injection of metaphen in oil.

7. Only one case of acute gonococcic urethritis failed to improve on metaphen in oil.

8. The average number of days required to render the discharge gonococci-free in cases of acute exacerbations of chronic gonorrhea was three—half the time required in cases of new infection.

9. No case failed to improve in the group of acute exacerbations of chronic gonorrhea.

10. The average number of days required to render the discharge gonococcus-free in the chronic group of cases was one and one-half days.

11. The discharge in this group of cases disappeared in an average of 11 days.

12. No case was encountered in this group which failed to clear up.

13. Excellent results were obtained when aqueous metaphen in a solution of 1:30,000 was used.

14. Metaphen in oil treatment proved very effective in most types of cystitis.

15. In the treatment of kidney infections the aqueous solution of metaphen was found superior to metaphen in oil on account of the possibility of oil embolus and also the oil solution adheres to the mucosa of the ureter interferring with drainage.

16. All cases of bladder infections treated with aqueous metaphen or metaphen in oil showed marked clinical improvement.

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THE MANAGEMENT OF IDIOPATHIC ULCERATIVE COLITIS

By MANFRED KRAEMER, A.B., M.D., and MAURICE ASHER, M.D., Newark, N. J.

Read before the Section on Gastro-Enterology of The Medical Society of New Jersey on May 2, 1935, at the Annual Meeting in Atlantic City.

We have used the word "management" rather than "treatment" in the title of this paper in order to avoid giving the impression that we would advocate the use of some specific drug, vaccine, or serum to cure chronic ulcerative colitis. As yet there is no specific remedy, and no cure, for chronic ulcerative colitis; and the physician who places reliance in a serum or in a particular vaccine, or in drugs alone will surely fail to control the disease.

Success in the care of patients with colitis comes only with the realization that cure is a receding goal which can never be crossed; but that by management and careful playing of the game, the patient can always be kept within scoring distance. It has been our experience that permanent cure cannot be anticipated in ulcerative colitis, and that if sufficient time is allowed, every case will relapse.

The common nature of peptic ulcer and colitis has often been considered in the literature, since in both diseases recurrence is common, cure is rare, and continuous treatment over many years is essential for relief.

SIMILARITY TO CHRONIC HEART CONDITIONS

For purposes of comparison we rather suggest that the patient with colitis be considered in the same light as a patient with some form of chronic heart disease. In heart disease failure is ever imminent, and at times it occurs without apparent cause; but it usually comes after exertion, or is secondary to infection elsewhere in the body; while in colitis severe exacerbations may result from no apparent cause or on very slight provocation, but most frequently they are brought about by undue physical or mental strain or are concommitent with infections elsewhere, especially those of the upper respiratory tract.

Organic lesions of the heart valves or cardiac musculature are never healed. The scarring of the bowel wall which occurs in colitis can never be replaced by growth of normal tissue. Cardiacs do not respond to any routine

specific form of therapy but do best when care is taken in the proper supervision of rest, exercise, diet, occupation, medication, and mental and emotional factors. The same holds true in dealing with colitis; since patients with this disease improve only if work, diet, exercise, rest, medication, physical therapy, and emotional states are carefully and properly managed.

PATHOLOGY

Before going further we shall interpose a brief description of the disease, "chronic ulcerative colitis", and a few words in regard to its diagnosis.

True ulcerative colitis is a disease characterized by ulceration of the mucosa of the rectum and colon, usually starting locally in the rectum, and in the course of months or years involving the entire large bowel and even the terminal ileum.

Proctoscopically the rectum and sigmoid have a characteristic appearance, depending upon the advancement of the disease. In the early stage edema and redness of the mucous membrane is the characteristic feature. Often the edema stiffens the bowel wall so that it fails to collapse, and the proctoscopist examining it has the impression that he is looking into a rigid tube. Later miliary abscesses are present on the entire involved area of mucous membrane, producing a granular appearance when the exudate is cleared away. It is *rupture of these pinpoint abscesses* which gives rise to the ulceration. The mucous membrane is always *diffusely* involved, there being no interposed areas of normal tissue as is the case in amebic colitis. Exudate and sloughing of mucosa at times produce a grey membrane which completely covers and hides the miliary ulcerations. The miliary ulcers bleed freely whenever they are touched with the proctoscope or with the cotton swab which is used to wipe away the exudate. As these ulcers heal, typical pocklike scars remain; and there are often streaked areas of white scarred tissue.

Along with healing there is infiltrative thickening of the colonic wall causing narrowing of the lumen; and often there is polyp formation. Malignant degeneration of such polyps has been discussed elsewhere in the literature.

The onset of ulcerative colitis is frequently sudden with all the signs of an acute infection. There may be twenty or more bloody stools per day. Temperatures may run as high as 106 degrees and usually are of the up and down or septic type. This acute stage may last for many weeks and be followed by an active chronic stage with diarrhea continued over many months. Repeated flare-ups may result in rectal stricture, and peri-rectal abscesses are not uncommon. Complete obliteration of the bowel lumen may occur, and perforation of the colon and resulting peritonitis should ever be watched for.

The most striking feature of the disease is the extreme variability in its onset and course. The onset may be so mild that the patient may note only increased softness of his stools, or only the presence of a bit of pus or blood; yet the x-ray may disclose involvement of the entire colon. The type of onset in no way foretells the subsequent course of the disease and the prognosis is always uncertain.

DIAGNOSIS

A history of frequent mucous discharges from the bowel should never provoke the diagnosis of colitis or mucous colitis. The term *colitis* implies the presence of *inflammation;* and unless this factor is present, the term colitis should not be used. Many persons at some time in their lives or even frequently have mucous or diarrheal discharges from the bowel. This is the physiological response of the colon to irritation,—nervous, mechanical, or chemical. We have had a patient, a physician's daughter, who has had a nervous mucous diarrhea for sixteen years. Yet this patient does not suffer from colitis, although the diagnosis of colitis has been made by physicians both in this country and abroad, many of whom never took the trouble to proctoscope her and observe that the mucous membrane of the bowel was normal in appearance.

The term "mucous colitis" must be dropped. A patient may have a nervous diarrhea or a discharge of mucus from the bowel due to ingestion of irritating food or drink, or to

allergy, but that in no way signifies the presence of inflammation or colitis.

PROCTOSCOPIC EXAMINATION

The diagnosis of colitis should never be made unless the lesions have been seen through the proctoscope, or unless a barium enema shows the typical silhouette produced by the inflammatory process. The diagnosis of ulcerative colitis is suggested by the finding of pus or blood in the stool. The disease varies so in its manifestations that diarrhea may not be present. To make an accurate diagnosis the proctoscopic examination is the most important procedure.

Rectal scrapings should be taken through the proctoscope and examined on the warm stage to rule out amebiasis. In cases with septic onset bacillary dysentery and tpyhoid fever are to be excluded by cultural or serological methods. A smear of the stool should be examined for tubercle bacilli to exclude tuberculous ulceration; though swallowed tubercle bacilli may at times appear without tubercular involvement of the gut.

Unstained mucosal smears in ulcerative colitis are identified largely by the presence of great numbers of pus and macrophage cells, and much cellular débris.

Proctoscopy will rule out a neoplasm of the lower bowel. We have seen one case of sigmoidal carcinoma which was treated for colitis and hemorrhoids for two years because of failure of a physician to make a sigmoidoscopic examination.

X-RAY EXAMINATION

In every case barium enema x-ray examinations must be made. These are not only valuable in ruling out new growths and diverticula, but they tell us of the progress and extent of colonic disease. In early cases, hyperirritability and spasm is the only x-ray evidence of ulcerative colitis. Later there is a disappearance of the haustral markings in the involved area. If improvement occurs, some of the haustral markings may return. In long-standing cases, as the wall of the bowel becomes increasingly infiltrated, the x-ray appearance is that of a rigid tube—the "lead pipe colon". Stricture and complete obstruction may also be determined by the barium enema.

GASTRIC FINDINGS

We do not consider that gastric achylia in any way plays an etiological or diagnostic rôle in this disease, but a fractional gastric test may aid in differentiating a diarrhea of gastric origin.

MANAGEMENT

We shall not mention all the therapeutic measures suggested in recent years. We have tried and given up many of them. We shall limit this report to a summary of those procedures which we have found of value, and which we apply in every day routine on a number of patients.

EXCLUSION OF AMEBIASIS

Along with a diet and other measures to be described later, but before disclosing to the patient the nature of the disease, we give a course of anti-amebic drugs regardless of whether or not amebae have been found in the stools. It is our opinion that at times amebae are missed even after very careful searches. We have seen three cases of what seemed to be ulcerative colitis completely and permanently cured of amebiasis by the precautionary use of amebacides. Previous to 1934 we gave emetin hydrochloride gr. 1 intramuscularly daily for nine days; but since then we have instead used vioform N. N. R. by mouth gr. 4 t. i. d., for ten days.

ASSURING THE PATIENT

The first step in successful management is the assurance of the patient that a proper diagnosis has been made. If a history is carefully taken and a physical examination is thoroughly performed; and a chemical and microscopic picture of the stool is obtained; and if the revelations of the proctoscope, fluoroscope, and roentgen plates are explained in understandable language, the patient will have confidence that all measures have been taken to establish a proper diagnosis.

After ruling out amebiasis and before presenting the plan of management, it is wise to tell the patient or some responsible relative of

the nature of the disease,—ulcerative colitis. The chronic course must be emphasized and permanent cure must never be promised. We usually say to our patients: "If you are careful to follow instructions and diet for many months or even a year or more, we may be able at some time to give you a probationary period of freedom from supervision. However, if there is any tendency to relapse, you must continue a strict regimen for many years."

SURGERY

If the patient is first seen during a severe exacerbation, or if the disease is introduced with temperature, diarrhea, and exhaustion, complete bed rest must be insisted upon. It is during this stage of the disease that surgical consultations are often requested by members of the family or by the family physician; and the surgical consultant is prone to suggest ileostomy or appendicostomy. While upon theoretical grounds such operations, which short circuit the fecal stream and give the large bowel rest or permit irrigation of the colon, seem logical, experiences with a number of cases have lead us to conclude that surgery of this type is a hazardous procedure, and that chances of death are much increased if surgery is performed. We cite the figures of Bargen of the Mayo Clinic: In 1923 of 57 cases of chronic ulcerative colitis, ileostomy was performed in 16, and there were 7 post-operative deaths; and only 7 deaths in the 41 patients who were not operated upon. In 1931, of 140 patients, ileostomy was performed on 10, of whom 5 died post-operatively. In the 130 patients not operated upon, only 2 deaths occurred. In the ten-year period, 1922-1932, of a total of 1348 cases treated, ileostomy was performed on 78, with 40 deaths, a mortality of over 50 per cent; while in the non-operated group of 1270 patients there were only 53 deaths, a mortality of 4 per cent. (Cf. Coll. Papers of Mayo Clinic, vol. 25, p. 194, Saunders.)

Despite the above figures, when patients seem to be going from bad to worse, it is most difficult to resist the lure of the surgeon, and to combat the insistence of the family that something be done. In a case referred by Dr. Harry Silver to the junior author (M. K.), the surgeons were most insistent on performing ileostomy when the temperature peaks were about 105 degrees. The patient, a boy of 14, weighed only 56 pounds, and there were profuse bloody discharges. Conservatism won out, and the value of resistence to surgical intervention was substantiated by the successful outcome of the case. Experience with this and similar cases has convinced us that those acutely ill patients who improve after surgical intervention do so, not because of their ileostomy, but despite it.

NUTRITION

In an acute attack while maintaining complete bed rest, adequate *nutrition* must be supplied. The usual dietician-supplied "diarrhea diet" used in most hospitals should be avoided. The carbohydrate content of these diets is generally too high, and a fermentative diarrhea may be added to one of infectious origin. Certainly if the patient is very ill, diet must be restricted to liquids, preferably boiled milk and beef soups. Cold fruit juices and other iced drinks, however tempting, stimulate colonic peristalsis and should not be given. As soon as possible we prescribe the nonroughage, high protein, high vitamin diet of Bargen and Victor.

In this acute stage of the disease *opium* is a stand-by. Not only does it relieve the patient from colicy pain and tenesmus, but it gives the bowel a much needed rest. If movements of the colon are not too frequent, we prescribe a 15-grain cocoa-butter suppository containing 1 grain of extract of opium and ⅛ grain of extract of belladonna. If a suppository cannot be retained, a mixture containing 10 minums of tincture of opium and 5 minums of tincture of belladonna to the 1 dram dose is administered by mouth. In addition we prescribe 15-grain doses of bismuth subgallate and calcium gluconate every three hours.

SERUM TREATMENT

We have used ulcerative colitis anti-streptococcus serum (Bargen) in a few acute cases in addition to the above-mentioned measures. Of this we are certain—that the serum did

not bring about cure since in all of these cases proctoscopy showed constant presence of typical lesions despite improvement in symptoms. However, the results seemed encouraging; but we have wondered if the arrest in symptoms might not have been due to the non-specific fever reaction produced by the horse serum, rather than to the antigens in the serum. We suggest a trial of plain horse serum in a series of cases. The cost of Bargen's serum ($36) for a course makes its use in the average case impractical, but if plain horse serum were equally effective, its extensive use would be feasible.

Some patents never have acute exacerbations, but run a chronic course from the start, and continue in a chronic manner throughout the course of the disease; but it has been our observation that in almost every case flare-ups occur from time to time. We are on the alert for such exacerbations; and when they are suggested by a slight showing of blood or an increase in the number of daily movements or by undue fatigue, we prescribe immediate bed-rest. We insist on bed rest if any of these patients are afflicted with but the mildest upper respiratory infection, since colds and sore throats promptly aggrevate the symptoms. By using these precautions we are often able to avoid a serious attack.

MORALE

A general rebuilding of morale is one of the most important steps in the management of patients with colitis. Many of these patients have given up all hope, and every relapse adds to their despair. While not promising cure to these unfortunates, we must help them over the rough spots with the crutch of assurance, and must paint for them a cheerful picture of a most uncertain future, even though it be one of semi-invalidism.

REST

Rest, both mental and physical, is of utmost necessity. As previously mentioned, at the slightest hint of exacerbation we confine our patients to complete bed rest. In the presence of colds, coryza, pharyngitis, and similar infections complete bed rest is enforced even though the temperature is normal. Whenever possible, vacations from work should be taken. If work during the week is essential, Sundays and holidays had best be spent in bed.

CASE REPORT

A married school nurse who had her first attack of colitis in December, 1933, was completely relieved of all symptoms after six weeks of rest at the Newark City Hospital. She returned to work and in a short time had a recurrence and in August, 1934, was again hospitalized. She improved, went home and did well, even complaining of constipation. She insisted on returning to work on December 1, 1934; and, though able to continue work under ambulant treatment, she has had diarrhea and tenesmus, has lost weight, and has been generally miserable ever since.

We have had some patients of sufficient means to sojourn in Florida during the winter months. We have found the relaxation and warm climate to have benefited them greatly.

DIET

So much that is false and misleading has been said of diet that we make the following statement of principles:

The diet must contain sufficient caloric value to maintain body needs and to replace lost weight, and must replace the proteins and salts and water lost in the rectal discharges.

The diet must contain no material which will mechanically irritate the bowel wall, and it must contain as little non-digestible material as possible in order to decrease the bulk which must be removed by the large bowel.

The supply of vitamins should be in excess of the usual requirements.

We have used the diet devised by Bargen and Victor, which fulfills all of the above requirements. We prescribe the additional foods as mentioned by Bargen, and in selected cases increase the amount of food on the original list.

We must condemn the practise of prescribing bran, whole wheat bread, agar, and mineral oil to colitis patients. These non-absorbable products only add to the work of a crippled colon.

We condemn the use of raw fruits and vegetables which we found had often been prescribed to our patients. Those vegetables which are permitted should be thoroughly cooked and

pureed. Fruits are to be skinned, pitted, and cooked.

For some unknown reason it has become the practice of physicians to restrict meats in cases of diarrhea and colitis. Patients are to be encouraged to eat large amounts of meat. There should be 80 grams of protein in the diet every day.

The use of milk alone, or milk and cereal diets alone, is to be condemned, as these diets do not fulfill adult nutritional requirements. Vitamin B can be supplied by the addition of yeast to the diet. Brewers' yeast as now sold in tablet form is convenient and pleasant to take.

While colitis is at times associated with an absence of free hydrochloric acid from the stomach, this finding is so infrequent that we do not hold it to be of etiological significance. We have never found the feeding of dilute hydrochloric acid by mouth to be of any value.

MEDICATION

Medication is aimed at slowing peristaltic activity and promoting healing. The former we can accomplish; but I doubt if we can so coat the bowel wall with stimulants or protect it with emollients that healing is fostered.

The drug of choice in the control of this disease is *opium*. We do not hesitate to use it on the slightest provocation, and have seen no cases of colitis become addicted to its use. The senior author (M. A.) has carried one case of colitis through 25 years and has used opium constantly through this period. At the present writing ¼ grain of extract of opium in a cocoa-butter suppository is sufficient to keep the bowels under control, although the patient has in the past required as much as 2 grains to the dose. We usually prescribe 10 minums of tincture of opium and 5 minums of tincture of belladonna to the dose, with sufficient syrup and aromatic water to make one dram. As diarrhea lessens we decrease the dosage of opium. In children of course the amount of opium must be less according to age.

Bismuth subcarbonate and bismuth subgallate in gram doses t. i. d. are used as adjuvants, but patients often complain that they are constipating. Kaolin seems helpful at times. We have blown the following powder mixture into the sigmoid with a powder blower resting inside a sigmoidoscope: Bismuth subgallate 30 parts, tannic acid 10 parts, sodium chloride 5 parts. Success has been variable since it is difficult to get patients to submit to frequent proctoscopic examinations.

We have hesitated to use silver preparations in the rectum for fear of producing argyria; but occasionally it is advisable to touch up an inflamed area with a five per cent solution of silver nitrate.

Much has been said pro and con in regard to the use of *calcium*. One gram of calcium gluconate may be given daily to supply the calcium requirements of the body. We have given as much as 6 grams of calcium gluconate per day for several weeks to many of our patients, but have failed to get the benefits attested to by other authors.

TRANSFUSIONS

Repeated small blood transfusions have been recommended by many men. We have found blood transfusions of no value in this disease, except in cases of blood loss where the red blood count fell below 2,500,000. We have seen no improvement in symptoms or in the appearance of the bowel wall where transfusions alone were used. The probability is that some of the improvement noted after transfusion is coincidental and not resultant.

CASE REPORT

A consultation was called for one of our patients after the patient had been confined to bed one month with uncontrolled diarrhea. One of the consultants recommended transfusion. Since the red cells were over 3,000,000, we did not concur in his opinion, and transfusion was not performed. Shortly thereafter improvement began. Had transfusions been given, relief would have been ascribed to that procedure.

COLONIC IRRIGATIONS

So-called "high colonics" do more harm than good. We cannot entirely condemn irrigation of the colon. Irrigations are definitely contraindicated during acute flare-ups; but in chronic cases they may be given.

We have had two cases which were considerably benefited by bi-weekly irrigations with 2 liters of a 1/10,000 copper sulphate solution

at 118 degrees F., after the method of De Rivas. These were both chronic afebrile bed patients. The irrigations were given by the physician and not entrusted to a nurse.

VACCINES AND SERA

Although we have found Bargen's organism in the stool of most of our patients, we cannot agree as to the value of vaccines made from this diplo-streptococcus. One of our patients with colitis developed a generalized pustular acne. Bargen's organism was found in pure form in material taken from these pustules. However, autogenous Bargen's vaccine did not cure her colitis.

The results obtained from vaccines made from all the organisms obtained from rectal scrapings have been just as beneficial as those made from Bargen's organism. Now we routinely use an autogenous vaccine made from the material obtained by scraping the rectal wall. One must be careful to keep the doses of the vaccine so small that local and general reactions do not result from its use. Such reactions, if they occur, are apt to provoke an increase in diarrhea.

We have used ulcerative colitis anti-streptococcus *serum* in too few cases to be in position to judge its value. No spectacular results were obtained by us with its use.

ULTRA-VIOLET THERAPY

In January, 1934, we empirically tried generalized ultra-violet irradiation in one of our hospitalized patients. The result was most satisfactory; and since then we have been using this modality in almost every case. We employ a quartz mercury lamp, the burner 30 inches from the body, starting two minutes front and 2 minutes back, and increasing one minute for each treatment up to 15 minutes. The patients are treated three times weekly for six weeks, and bi-weekly thereafter. We cannot explain the tonic effects of this treatment but we can testify that it is beneficial. A child of eleven years had been treated by diet, rest, vaccine, and medicine for several months, but showed no real subsidence in symptoms until after a course of irradiation.

SURGERY

We think an epoch of appendicostomy and ileostomy in this disease is drawing to a close. The mortality in these palliative procedures is too high, 50 per cent (Bargen's figure at the Mayo Clinic); and 27 per cent (Cattell at the Lahey Clinic) represent what occurs in the hands of the best surgeons. Surgery in the future must concern itself with colectomy in chronic cases where the involved area is localized, and where the lumen of the bowel wall is completely stenosed. In cases of perforation, surgery must always be attempted.

SUMMARY AND CONCLUSION

1. Chronic non-specific ulcerative colitis is a disease which is not curable, and in which relapses always occur. By careful management the symptoms may be kept under control.

2. The important factors in management are the up-building of the patient's morale, and the adequate supervision of rest, diet, medication, and physio-therapy.

3. The drugs used in order of their importance are: Preparations of opium, bismuth, kaolin, calcium, and tannic acid.

4. Vaccines and sera have their place, but are neither specific nor curative. A vaccine made autogenously from rectal scrapings has proven as satisfactory as those prepared from a specific organism.

5. Colonic resection in cases of partial stenosis and emergency operations for perforations are the surgical procedures of importance.

SOME PRACTICAL OBSERVATIONS CONCERNING OPHTHALMIC LENSES

By A. Russell Sherman, M.D., Newark, N. J.

Read before the Eye, Ear, Nose, and Throat Section at the Annual Meeting of The Medical Society of New Jersey on June 9, 1934, at Atlantic City.

This paper is concerned with four of the properties possessed by spectacle lenses. It attempts to explain the parts they play in the correction of errors of refraction, and to point out their importance or unimportance under different conditions. The subjects to be considered are the distance of the lens from the eye, the shape of the lens, the prismatic effect of decentration, and the astigmatism of oblique pencils.

THE DISTANCE OF THE LENS

Everyone who performs refraction knows that as a lens is placed farther from the eye, the result is an increase in its converging or decrease in its diverging effect. It is worth while to consider this phenomenon in some detail and to make suitable allowance for it in prescribing lenses of higher powers for aphakia and high myopia. In general, a change of position of one centimeter produces a change of one diopter in a 10 D. lens, and there are available tables from which can be determined the effect of a change in the position of the glass.

For example, in a specific case, the distance between the apex of the cornea and the vertex of the lens in the trial frame has been 17 mm., and it has been found that a —15 D. lens is required. When the patient is fitted with a permanent spectacle, let it be assumed that it is desirable or necessary to place the lens 12 mm. from the cornea (12 or 13 mm. is considered the optimum distance). Reference to the table[1] shows that a lens of —15 D. placed 17 mm. from the cornea has the same effect as one of —14 D. 12 mm. from the cornea.

Therefore the proper correcting lens for this eye, placed 12 mm. from the cornea, is —14 D., not —15 D.

The question of the position of the lens in myopia of this degree is sometimes not so important because of the diminished visual acuity resulting from the degenerative changes that are so often present. It is of considerable importance, however, when one is dealing with a patient who has had a successful cataract operation performed in a healthy eye. A table for convex lenses[2] used in the same manner, shows that a +13 D. lens at 17 mm. must be changed to a +14 D. for use at 11.5 mm.; and a +11 D. lens at 16 mm. to a +11.50 at 12 mm.

DEFINITIONS

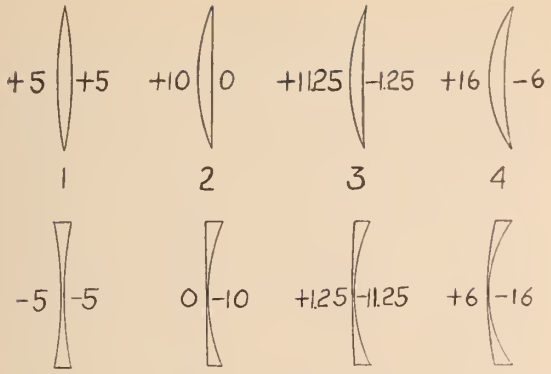
Of no less importance than the distance from the eye is the form of the lens. Before considering this subject one should review, if necessary, the definitions of certain essential terms.

The *principal points* of a lens need not, for our purposes, be too exactly defined. They are two in number, anterior and posterior, situated very near each other on the optical axis, and are of great importance in geometric optics. In an equal-sided lens both principal points lie inside, but for lenses of other forms they may lie on the surface of, or outside the lens. Passing through each of these principal points is a *principal plane* perpendicular to the optical axis.

The *principal foci,* anterior and posterior, are those points at which are focused parallel rays after passing through the lens. Corresponding to the principal planes are two *principal focal planes,* each passing through one of the principal foci, perpendicular to the optical axis.

The *focal length* is the distance from a principal point to its corresponding principal focus (or from a principal plane to its corresponding principal focal plane); and its reciprocal, expressed in diopters, is the *equivalent* power or *principal point* refraction. (Thus a lens with a focal length of 0.1 meter has a principal point refraction of 10 D.)

The focal *intercept* is the distance from the *vertex* of the lens to its corresponding principal focus; and its reciprocal, expressed in diopters, is the *effective* power or *vertex* refraction.



Type	Focal Length in mm.	Principal Point Refraction in D.	Focal Intercept in mm.	Vertex Refraction in D.
Biconvex	101.83	+ 9.82	100.20	+ 9.98
Planoconvex	100.20	+ 9.98	97.28	+10.28
Periscopic	99.90	+10.01	96.43	+10.37
Meniscus	98.33	+10.17	93.20	+10.73
Biconcave	—100.00	—10.00	—100.20	— 9.98
Planoconcave	—100.20	— 9.98	—100.20	— 9.98
Periscopic	—100.30	— 9.97	—100.20	— 9.98
Meniscus	—100.50	— 9.95	—100.20	— 9.98

Fig. 1.—Lenses in Common Use: 1, Biconvex and —Concave; 2, Planoconvex and —Concave; 3. Periscopic Convex and Concave; 4, Convex and Concave Meniscus.

TYPES OF LENSES

One should have clearly in mind also, the four types of lenses in common use—the *equal sided;* the *plano;* the *periscopic,* having in plus powers a constant back surface of —1.25 D. with a variable front surface; and in minus powers a constant front surface of +1.25 D. with a variable back surface; and the *meniscus,* erroneously called toric, ground on the same principal as the periscopic, except with curves of —6 D. and +6 D. instead of —1.25 D. and +1.25 D. These are shown in figure 1.

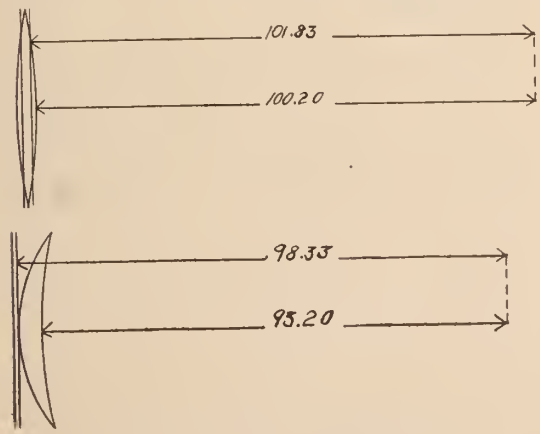


Fig. 2.—Focal Lengths and Intercepts (in mm.) of +10 D. Equal Sided, and Meniscus Lenses.

THE FORM OF THE LENS

The effect of the form of the lens, in the higher powers, is illustrated in figures 2 and 3, showing the position of the principal planes and foci of equal-sided and of meniscus lenses.

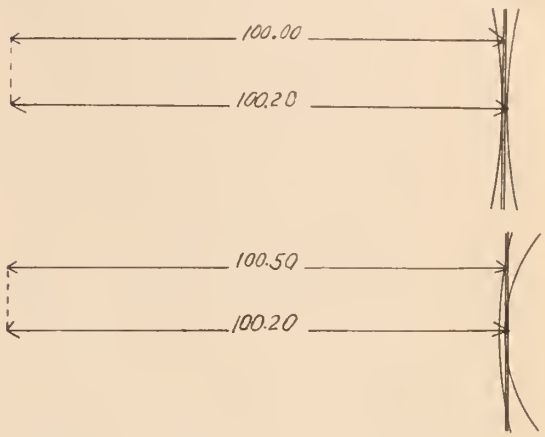


Fig. 3.—Focal Lengths and Intercepts (in mm.) of —10 D. Equal Sided and Meniscus Lenses.

Reference to figure 1 again, giving the focal lengths and intercepts, principal point, and vertex refractions of various 10 D. lenses, shows that a 10 D. biconvex lens has a focal length of 101.83 mm., and a principal point refraction of +9.82 D.; on the image or eye side its focal intercept is 100.20 mm. and its vertex refraction +9.98 D. The difference between the equivalent power and the effective power is negligible.

This is not the case, however, with the ordinary meniscus lens, ground on a —6 D. base curve. One finds now that the principal point refraction is +10.17 D., but the vertex refraction is +10.73 D., in round numbers 0.50 D. stronger. A comparison of the effective powers (or vertex refractions) of +10 D. equal-sided and +10 D. meniscus lenses shows a still greater disparity,—0.75 D. Variations of this sort do not occur among the 10 D. diverging lenses. Their refractive powers expressed in terms of vertex and principal point refraction show a difference of only 0.05 D. between the highest and lowest values.

It will be noted that in this table, among sixteen figures expressing the power of 10 D. converging and diverging lenses, there are ten different values, and that in only one case is there a focal length of 100 mm. with a refrac-

tive power of 10 D. One might well at this point raise the question as to just what is a 10 D. lens, and the answer is found in the formula known to most opticians, $D=\frac{n-1}{r}$ —in which D. represents the power of the refracting surface, n the index of refraction, and r the radius of curvature, expressed in meters. In a 10 D. biconvex lens, then, with each surface having a power of +5 D., the radius of curvature is 104 mm., since the glass used in spectacle lenses has a refractive index of 1.52. This holds for thin lenses.

Figure 4 compares the effect of two lenses so placed that the vertex of the glass is in each case the same distance from the cornea. It will

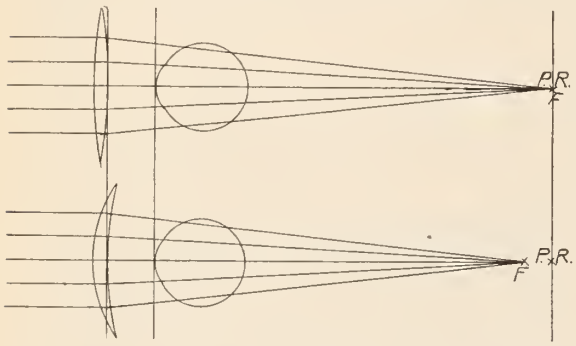


Fig. 4.—Correction of Hyperopia by an Equal-Sided Lens, and by a Meniscus Lens. P. R.—Punctum Remotum of Eye; F.—Principal Focus of Lens.

be noted that although these lenses are of equal strength, as calculated from the radii of their surface curves, the second principal focus of the correcting lens coincides in the one instance with the far point of the eye; and that in the other it is several mm. from it.

The difference between the biconvex and convex meniscus lenses increases rather rapidly in strengths above 10 D., a 20 D. biconvex lens, for example, having a vertex refraction of +19.9 D. and a meniscus a refraction of +27.36 D.,—a difference of 7.5 D. With diverging lenses, one need not take into account differences in form, since the biconcave, plano, periscopic and meniscus forms all have vertex refractions of —19.94 D.

The astigmatism of oblique pencils should properly be taken up in connection with lens forms, but will be postponed until after a consideration of prismatic effects of decentration.

CERTAIN PRISMATIC EFFECTS OF DECENTERED LENSES

The prismatic effect of decentered lenses sometimes becomes a matter of considerable importance, as for example in patients with anisometropia, when reading. It is reasonable to consider the direction of gaze as passing through a point midway between the center and the lower edge of a spectacle lens when one reads. The average lens being 40 mm. in diameter, this point is 10 mm. below the center of the lens, and in a 1 D. lens a prismatic effect of one prism diopter has been introduced. If, in a pair of spectacles, one lens is —1 D. and the other —3 D., there are present prisms one- and three-prism diopters, bases down, making a difference between the eyes of two prism diopters, a by no means negligible amount. If the anisometropia is greater, or if the patient looks through the lens below this point, the prismatic effect is correspondingly greater. The remedy is separate reading glasses with lenses suitably decentered, or with ground-in prisms, to minimize the objectionable effect in the lower field.

A similar prismatic effect is produced when a patient is given astigmatic lenses whose axes are more or less symmetrically oblique, such as axis 135° in the right eye and 45° in the left. When he looks down and right, the cylinder of the right eye will act as a prism; when he looks down and left, that of the left eye will have the same effect. If a full correction calls for fairly strong cylinders, the vertical displacement may be so great that it is intolerable, and it may be necessary to undercorrect the astigmatism.

ASTIGMATISM OF OBLIQUE PENCILS

It is not possible or desirable at this point to go into the theory of the astigmatism of oblique pencils. That such a phenomenon occurs is obvious to anyone who understands elementary principles of the refraction of light by lenses, or who has observed the distorting effect produced by tilting a condensing lens or burning glass so that its optical axis is not parallel with the incident rays. It is desirable for oculists who are correcting refractive errors to appreciate the extent to which this as-

FIGURE 5.

ASTIGMATISM OF OBLIQUE PENCILS ARISING IN SPECTACLE LENSES OF DIFFERENT TYPES AND POWERS

Equal-sided Lenses

Vertex Refraction in D.	Astigmatism in D.
+ 2	+ 1.22
+ 4	+ 2.75
+ 6	+ 4.81
+ 8	+ 7.68
— 2	— 0.69
— 4	— 1.34
— 6	— 2.01
— 8	— 2.74
—10	— 3.58
—12	— 4.62
—14	— 5.97
—16	— 7.77
—18	—10.31
—20	

Plano-spherical Lenses

Vertex Refraction in D.	Astigmatism in D.
+ 2	+0.94
+ 4	+1.60
+ 6	+2.13
+ 8	+2.62
— 2	—0.55
— 4	—0.81
— 6	—0.88
— 8	—0.84
—10	—0.73
—12	—0.56
—14	—0.39
—16	—0.22
—18	—0.09
—20	—0.01

Perioscopic Lenses

Vertex Refraction in D.	Astigmatism in D.
+ 2	+ 0.64
+ 4	+ 1.11
+ 6	+ 1.48
+ 8	+ 1.83
— 2	— 0.39
— 4	— 0.55
— 6	— 0.56
— 8	— 0.47
—10	— 0.31
—12	— 0.13
—14	— 0.06
—16	— 0.23
—18	— 0.37
—20	— 0.45

Meniscus Lenses

Vertex Refraction in D.	Astigmatism in D.
+ 2	+0.05
+ 4	+0.09
+ 6	+0.15
+ 8	+0.32
— 2	—0.03
— 4	—0.05
— 6	—0.17
— 8	—0.36
—10	—0.56
—12	—0.76
—14	—0.92
—16	—1.05
—18	—1.08
—20	—1.01

tigmatism enters into their work, so that they may avoid having their patients furnished with poorly-formed lenses, and at the same time avoid being deluded by the extravagant, if not false claims of the lens manufacturers and by certain opticians who either deliberately aid and abet the manufacturer, to their own pecuniary advantage, or are themselves deceived by the propaganda.

Figure 5[3] shows the astigmatism at the periphery of lenses of various strengths and forms.

It is noted that a +8 D. biconvex lens, used in most trial sets, has 7.68 D. of astigmatism at the periphery. The biconvex is, therefore, in the higher powers, a very poor type of lens. This should be relatively unimportant, for such lenses are practically never used in spectacle frames. One must, however, beware of the ignorant optician who, having discovered that a patient with aphakia sometimes does not obtain as good vision with his permanent glasses as he did in the oculist's office with the trial lenses, attempts to protect himself by furnishing the lens which resembles most closely that used by the examiner.

The ordinary +8 D. meniscus, ground on a —6 D. base curve has only 0.32 D. of astigmatism at the periphery. This amount is insignificant when it is remembered that a person who is looking intently at an object never gazes through the periphery of the lens, but prefers to change the position of his head, so that he looks much more nearly through the center. Moreover, when the visual axis is directed through the center of the lens, or even several mm. from it, objects so located that they send rays of light through the periphery form images on the retina at a considerable distance from the macula. The visual acuity of the edge of the macula is scarcely better than 20/200, so that it is inconceivable that 0.32 D. of astigmatism or several times as much could possibly have any perceptible effect on the eyes of a person wearing such lenses.

A —8 D. meniscus has a correspondingly small amount of astigmatism at the periphery, and for diverging lenses of greater strength one can obtain forms having still less astigmatism at the periphery by selecting suitable periscopic or plano types. In fact, suitable lens forms can be so selected from the ordinary plano, periscopic and meniscus types that in powers from —20 D. to +8 D. there is never more than 0.50 D. of astigmatism at the periphery, all without any recourse to the greatly exploited "point focal", "corrected", or "precision" lenses.

The curves devised by Rönne[4] (Figure 6) enable one to choose very quickly the lens of best form in the ordinary powers. In this figure lens powers are plotted horizontally, and the astigmatism arising from obliquity of gaze vertically. The various lens forms are indicated as follows: - x - x - equal-sided; ------- plano; ------ periscopic; ----- Tscherning's; ---- Zeiss; the continuous line represents the meniscus form. The values for astigmatism are lower than the corresponding ones in figure 5 because they are calculated for a point 10

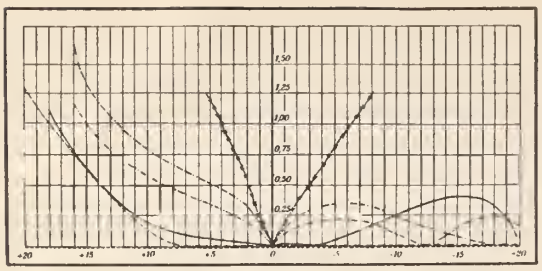


Fig. 6.

mm. from the center instead of from a point at the periphery of the lens. It will be noted that by selecting a meniscus for the lower powers and a periscopic or plano for the higher, one can obtain diverging lenses up to —20 D. which produce not more than 0.25 D. of astigmatism when the gaze is directed 10 mm. from the center; converging meniscus lenses up to +10 D. are equally free from any objectionable astigmatism.

In this connection I should like to quote Coblentz,[5] who writes, "With this temporary let-up in the exploitation of tinted lenses, the merits of new types of wide-vision lenses (the 'Punktals' and so on) are being extolled. According to recent investigations, the importance of this improvement appears to be greatly overestimated. Just how this type of lens will benefit the average wearer, and just why he should be put to the extra expense of procuring a pair, is questionable. It is true that such a glass may aid a little in the clearness of perception by indirect vision; but once the attention is called to an object on the sideline, the average person will turn the head and hence will profit but little by the use of such a lens in viewing an object in straight ahead vision. In other words, for a reading lens that may have to be changed frequently and that is used only in a sedentary occupation, it is not clear why the many wearers should be put to the expense of procuring a special lens that may perhaps be necessary only for the unfortunate few." Percival[6] also, in a recent article, calls attention to the fallacy of the "precision" lens as follows: "For instance, if a +6 D. periscopic lens is required for reading, its ocular surface should be about —4.5 D.; but if the same power is required for distance, its ocular surface should be about —7 D." As long ago as 1917 Rönne[4] pointed out that the —10 D. Punktal lens with a +2.50 D. front surface should have a plane front surface if it was to be free from astigmatism of oblique pencils at 33 cm.

It is impossible to believe that any lens is perfect when perfection requires different curves for different distances. Nevertheless, the oculist is confronted constantly with extravagant claims for certain lenses which are almost as ridiculous as some of the patent medicine advertisements. Whoever prescribes such lenses for average eyes classes himself with those who through laziness, ignorance, or both, habitually order proprietary medicines. In fairness to his patients and to his own intelligence the oculist should become acquainted with the surface curves of commercial spectacle lenses so that he can specify the most desirable forms, and he should refuse to prescribe the over-publicized products except in very rare cases.

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DEEP ROENTGEN RAY THERAPY IN THE TREATMENT OF DISTURBANCES OF THE AUTONOMIC SYSTEM

By A. J. DELARIO, M.D., and F. R. MEYERS, M.D., Paterson, N. J.

From the Departments of X-Ray and Cardiology, St. Joseph's Hospital, Paterson, New Jersey. Read before a meeting of the Hospital Staff, September 26, 1934

The object of this paper is to report the results of x-ray applications to the sympathetic nervous system in conditions of its hypersensitivity. Good results have been obtained in some diseases and improvement in others.

Sympatheticotonia	*Vagotonia*
1. Dryness of skin	1. Hyperidrosis (excessive sweating)
2.	2. Dermatagrophism
3.	3. Urticaria
4. Dryness of eyeballs	4. Epiphora
5. Infrequent winking	5. Frequent winking
6. Exophthalmos	6. Enophthalmos
7. Wide pelpebral fissure	7. Narrow palpebral fissure
8. Mydriasis	8. Myosis
9. Paralysis of accommodation	9. Accommodation spasm
10. Inability to maintain convergence of eyeballs	10.
11. Ocular cardio-reflex negative	11. Ocular cardioreflex plus
12. Hyperactive gag reflex	12. Sluggish gag reflex
13. Dryness of mouth	13. Salivation
14.	14. Bronchiolar spasm
15. Tachypnoea	15. Irregular respiration
16.	16. Pulsis irregularis respiratonis
17. Tachycardia	17. Bradycardia
18. High blood pressure	18. Low blood pressure
19.	19. Esophagospasm
20.	20. Visceroptosis
21. Hypochlorhydria	21. Hyperchlorhydria
22. Hypomotility	22. Hypermotility
23.	23. Vomiting
24. Atony of stomach	24. Pylorospasm
25.	25. Spastic colitis
26. Constipation	26. Diarrhea
27.	27. Mucus colitis
28. Incontinence	28. Pollakiuria
29. Lowered carbohydrate tolerance	29. Increased carbohydrate tolerance
30. Epinephrin hypersensitivity (i.e., epinephrin acts in smaller amounts and more rapidly than normal)	

CHART 1. CONTRASTING SYMPTOMS OF AFFECTIONS OF THE SYMPATHETIC AND THE PARA-SYMPATHETIC NERVOUS SYSTEM

The theory of the treatment is explained, and a preliminary report of cases is given, including angina pectoris, hypertension, and hyperthyroidism.

Certain abnormal conditions may exist which present no gross, nor in some cases, microscopic pathological signs; and yet, they make themselves evident clinically by symptoms which indicate hyperactivity or hypersensitivity of the sympathetic or parasympathetic systems.

PHYSIOLOGY OF THE SYMPATHETIC SYSTEM

The autonomic nervous system is composed of the sympathetic and parasympathetic nerves and their cells. It has two functions like the spinal nervous system:

1. It conducts impulses to the cells it ennervates (an efferent function).

2. It conducts impulses to the central nervous system (an afferent function).

By their efferent functions the sympathetics are stimulators of the muscles of the circulatory system, both of the heart and of the blood vessels, are inhibitors of the muscles of the bronchi and gastro-intestinal tract, and both

stimulators and inhibitors of the muscles of the genito-urinary system.

The parasympathetics are inhibitors of the muscles of the circulatory system; stimulators of the muscles of the bronchi and gastro-intestinal tract; and stimulators of the muscles of the bladder.

The sympathetics are for the most part stimulators of the endocrine glands while the parasympathetics are inhibitors.

Hyperactivity and hypersensitivity of the sympathetic system may produce a state of the body known as *sympatheticotonia;* while a degenerate. Some, therefore, believe that stimulation causes the corresponding ganglia to form adrenalin or a pilocarpin- or cholin-like substance, which in turn stimulates the organs they ennervate. The adrenals are stimulated only when greater activity is needed. Others believe that the ganglia merely act as distributing centers of stimuli, conducting impulses to and from the visceral organs in the same way as do the spinal nerves.

When a disturbance in the equilibrium of the autonomic system is slight, various drugs which influence the system may be tried, after

Parasympathetics	Inhibitor	*Epinephrin*:	Stimulates motor-end plates even though corresponding ganglia are extirpated
		Thyroxin: *Cocaine*:	Render sympathetic endings more sensitive to normal stimuli; they lower the threshold
		Pituitrin:	Causes contraction of all smooth muscles, especially those supplied by the inferior mesenteric plexus; causes the secretion of milk
	Stimulator	Ergotoxin, Nicotine	First stimulate, then paralyze
Sympathetics	Stimulator	*Picrotoxin*:	Is a central stimulant
		Pilocarpin and Cholin:	Stimulate motor-end plates
		Physostigmin:	Sensitizes nerve endings
	Inhibitor	Atropin, Homatropin	Paralyze motor-end plates

CHART 2. THE EFFECTS OF DRUGS ON THE SYMPATHETIC AND PARASYMPATHETIC NERVOUS SYSTEMS

similar condition of the parasympathetic system will produce the state known as *parasympatheticotonia* or *vagotonia.* The contrasting symptoms of these two conditions are shown in Chart 1, page 287.

Sometimes increased activity of parts of both the sympathetics and the parasympathetics may exist in the same individual.

The autonomic system is depressed or excited by mineral changes in the body, such as an increase in calcium or potassium, or by the following drugs, as shown in Chart 2.

How the autonomic system works is not definitely known. Adrenalin will cause vasoconstriction, even though the corresponding sympthetic ganglia are extirpated. Pilocarpin and cholin will cause vasodilatation even if the corresponding parasympathetics are caused to

such sources of autonomic irritation as mineral imbalance and chronic infections have been eliminated. Recently Stammler[18] concludes that infectious diseases cause pathological changes in the autonomic ganglia.

In autonomic imbalance or in definite clinical entities caused by autonomic disturbances which are not influenced by drugs, we believe that deep roentgen ray therapy can be of value, especially in cases in which surgery is counter-indicated.

By its afferent function the autonomic system often conducts painful sensations from areas which normally do not give rise to them. These painful impulses usually pass to the spinal cord along the dorsal roots, but in some cases may pass along the ventral roots also. It thus becomes apparent that section of only

the dorsal roots for the removal of pain may not always be successful, and, of course, section of the ventral roots cannot be attempted because of paralysis. Here, then, extirpation of the ganglia conducting these painful stimuli is of great importance.

But the anatomy and physiology of the autonomic system is not definitely understood; the surgery of this system is difficult, and because of this lack of fundamental facts surgery is also quite often unsuccessful. Also, it may be advantageous merely to depress the nervous conduction rather than to sever it, so as not to completely lose the efferent stimuli. X-ray offers this possibility. If it is necessary to interrupt the pathways more extensively because of a transference in route, we can accomplish it. Regenerations have been known to occur after surgery.

With x-ray, we can control them, by further irradiation. In brief, with the roentgen ray we have some semblance of control and the power of progressive treatment, which is lacking in surgery.

Bradshaw[3] has shown that x-ray therapy causes ganglionic cells to become depressed; i. e., they lose their Nissl substance which is necessary for ganglionic activity. This prevents hyperactivity of either the sympathetic or the parasympathetic systems, and makes it difficult for painful stimuli to reach the central nervous system. This depression is not temporary, but is, so far as we know, permanent.

ANGINA PECTORIS

Of all the ailments to attack the human body there is probably none more painful and discomforting than angina pectoris. Once the syndrome is established, the fear of an impending attack is almost as annoying to the patient as the actual attack itself.

We all appreciate how difficult it is to influence the course of the disease by drug therapy. Evans and Hoyle[8] state that continuous drug treatment by sixteen active drugs demonstrated that the seizures were not affected by medication either as to frequency or severity. Their conclusions in another article[9] were that glyceryl trinitrate is the only effective remedy, and that only for the relief of established attacks, or for their immediate prevention. However, cases occur in which this remedy also fails to give relief, and occasionally even fails to diminish the severity of the seizure.

Short wave diathermy has been employed, but the results are not gratifying, and the treatment must be employed with great exercise of judgment. It is not uncommon for a crisis to occur during the treatment, or immediately following.

There are various theories for the cause of angina pectoris, but that which is most likely is an ischemia of the musculature. The etiology of the interruption in blood supply may be variously listed:

1. Coronary arterial sclerosis with loss of elasticity and with or without much calcification and narrowing of the coronary arteries.

2. Coronary vascular spasm, superimposed perhaps in the smaller vessels, on sclerosis of the larger trunks.

3. Coronary mouth occlusion by luetic aortitis, or other factor.

4. Pronounced aortic regurgitation, and advanced aortic stenosis.

5. Anomalies of the coronary arteries.

6. Thyrotoxicosis and marked anemias favor the onset of the syndrome.

The pain impulse is conducted to the central nervous system, by means of the sympathetics, through the first four thoracic ganglia, and through the upper, middle, inferior, and stellate ganglia on both sides of the neck. (Jonnesco, Enarchesco;[14] Broeucker;[4] Kuntz-Morehouse.[15])

Anything which interrupts the nerve pathway over which the pain impulses travel will, of course, relieve the pain; and, at the same time, if the impulses leading to the coronary system are depressed, any vascular spasm existing will be modified. With the modification of vascular spasm the blood supply may be increased, and the morbid anatomy of the musculature permanently influenced for the better.

Surgical procedures have been employed since 1916 for the interruption of these nerve

pathways, and the results are well known. However, it is apparent how extensive surgery must be in order to be sure that results will be successful. In the Massachusetts General Hospital, when only the upper cervical ganglia were removed, good results were obtained in but 37.5 per cent of cases; when complete cervical sympathectomies were done, good results were obtained in 50 per cent; and when thoracic sympathectomies were done, good results were obtained in 100 per cent of the cases. (White, Garrey, Atkins.[23])

It seemed to us that deep roentgen ray treatment would be suitable for angina pectoris for the following reasons:

1. It depresses the sympathetic ganglia so as to prevent spasm of the coronary arteries.

2. It raises the threshold of nervous conduction so that the painful stimuli caused by such spasm might not reach the central nervous system.

With this thought in mind, therefore, we undertook to treat angina pectoris with x-ray therapy, and obtained excellent results, as the following case report will show. It is interesting to note the various symptoms of increased activity of the autonomic system in all our cases, and the modification of these symptoms after x-ray therapy.

Case I. Patient G. L., age 67, retired. For the past two years he had had anginal pains distributed over the left chest, neck, into the throat with choking sensations, and radiating to the left arm. These were induced at first by exertion, but later they also occurred while he was at rest. In February, 1934, the attacks became much worse, and in March they came so often that they were almost continuous.

For the past twenty-five years the patient has had neuritis peripherally, and now has loss of control of purposeful movements to some degree. In fact, at one time, if he attempted to execute some movement with the left hand and much shaking occurred, an attack of angina would be produced.

On March 29, 1934, a physical examination disclosed existence of neuritis. There was some evidence of slight exophthalmos, excessive lacrimation, and slight dilatation of the pupils. The heart was slightly enlarged to the left; when erect an indistinct systolic murmur was heard at the apex; there was some reduplication of the second sound; regular sinus rhythm was present, and P2 was greater than A2. The blood pressure was 160/100. There were no other remarkable findings. The urine was negative.

Between March 29 and May 22, despite the use of the usual drugs and rest, the patient became gradually worse. The blood pressure fell to 140/90 and remained there. One occasion found him prostrated on the floor of his home where he had been for over an hour, unable to move, in a seizure of pain. On this occasion one-half a grain of morphine did not give relief or cause sleep, although it was augmented by mouth with nitroglycerine.

On May 28 roentgen ray therapy was begun, and from that date to August 16, 1934, the patient received three series of treatments irradiating the right and left anterior cervical regions, and three series of treatments to the first ten thoracic vertebrae posteriorly, the following factors being used: 180 kilovolts, 5 milliamperes, 40 cm. distance, .8 mm. Cu., 3 mm. Al., using a 10 by 15 cm. field over the cervical region anteriorly, and a 20 by 20 cm. field over the thoracic region posteriorly, and giving 260 R units, or nearly one-third of a skin erythema dose per field per week.

Following the second exposure on June 6 the patient's blood pressure fell to 125/75, and, although he is receiving no medication, has averaged 125/82 ever since.

On July 6 the reduplication at the apex has disappeared. He felt much improved and had been totally free of any attack for eight days past. Between July 6 and 20 he had an occasional dull precordial pain of small magnitude appearing in the prone position and easily relieved by sitting upright. Between July 20 and September 19 he had only one small attack of pain and this lasted only two or three minutes. He stated on the latter date that he felt very well except for occasional eructations of gas. He had lately gained weight and could indulge in exertion without trouble. There was less widening of the palpebral fissure, his pupils were slightly smaller, and lacrimation had disappeared.

An electrocardiogram taken on September 18 had as its most significant feature inversion of the T wave in all three leads, indicating coronary disease; thus confirming the original diagnosis and demonstrating the existence of present pathology although pain has been interrupted.

Attention is directed to the fact that although under medication and rest the blood pressure, previous to roentgen ray treatment, never fell below 140/90, but since that time, totally without medication and with renewed activity and exertion, it has averaged 125/82. The highest recorded at any time since has been 130/88.

Case II. R. O., age 53, weight 110 pounds, has had pains in the precordial region for the past two, to three years. These pains came along at any time, whether the patient was at rest, or active, and often came after meals. They were of sharp, knife-like nature, radiating to the left arm, shoulder, and back. The patient has been short of breath for the past three years, and for the past six months dyspnea has been very severe. She was unable to climb even one flight of stairs. Night cough is present. She had edema of the left ankle for the past two months, which, however, disap-

peared with rest in bed. Has nocturia twice, and diuria four to five times. She had diabetes two years ago, associated with polyuria and pruritis. The patient had her menopause four years ago, and at this time also had rheumatism of the knees.

PX: The patient had exophthalmos, widening of the palpebral fissure, dilatation of pupils, warm moist skin. Her heart was slightly enlarged, and there was a systolic apical murmur well transmitted. Eyegrounds were negative, urine showed specific gravity of 1.016 to 1.028, albumin 2 plus, faint trace of sugar at times, although the blood sugar was 108 mgm. per 100 cc. Wassermann was negative. Her blood pressure in November, 1933, was 220/110. An electro-cardiogram taken on January 3, 1934, revealed inversion of the T waves in leads 1 and 2, indicating the existence of coronary disease.

Since drugs had no effect on the pains, a cervical sympathectomy was decided upon. The left superior and inferior cervical ganglia were removed March 8, 1934. The patient immediately felt better, her pain disappeared, her blood pressure dropped to 110/75. She developed a left Horner's syndrome. The patient continued to feel perfectly well until August 1, 1934, when she began to be awakened at night with severe sharp pains in the precordial region as before, lasting one-half hour or more. This time her right side and right epigastric region also became affected.

X-ray therapy was started on August 15. We gave two series of treatments to the cervical regions only, as outlined in Case I, after which the patient's pains almost completely disappeared. On September 20, 1934, her blood pressure was 110/60. Irradiation of the right cervical region seems to have caused in the right eye a degree of enophthalmos and relative narrowing of the palpebral fissure, myosis, and ptosis of the lid, similar to that present in the left eye in which surgical extirpation of the sympathetics had caused a Horner's syndrome.

IRRADIATION OF THE SYMPATHETICS CAUSING RELIEF OF OTHER TYPES OF PAIN

Cervical, thoracic, and lumbar sympathectomies, and periarterial sympathectomies have all been successfully used in relieving pain conducted by the sympathetics. We all know that deep x-ray therapy also relieves pain by depression of the sympathetics. This has been shown time and again in the irradiation of cancer of the internal organs. Pain has been relieved in conditions caused by spasm or decrease in the blood supply, such as Raynaud's disease, Berger's disease, and in endarteritis of other origin. Not only is pain relieved, but there is actual improvement, by vasodilatation, of partial gangrenous conditions caused by arterial sclerosis, diabetes, thrombosis, and frost bites. Pain has been removed by surgical sympathectomies in migraine, trigeminal neuralgia, and painful stumps.

AORTIC ANEURYSM

A case of aneurysm of the descending aorta was recently treated for the relief of pain by deep roentgen ray therapy, and excellent results were obtained, as the following report will show:

Case III. T. D., male, age 59. Patient first came under observation on December 8, 1931. At that time he complained of sudden sharp severe pain in the chest, bilateral in distribution. He had great difficulty in swallowing food at times, but the pain had no relation to meals. Exertion seemed to play no part in the attacks.

At that time his blood pressure was 135/95. Interspersed with gallop rhythm were occasional ventricular extra systoles. No murmurs were heard. There was no gross enlargement. Examination of the chest revealed nothing abnormal. X-ray investigation, however, revealed an aneurysm of the descending aorta, causing the displacement of the esophagus forward and to the right. Considerable cardiospasm existed. Wassermann and urine examination were negative.

Under medication improvement occurred. However, in June, 1933, the trouble returned, and became more agonizing and severe. At this time nausea, and vomiting occurred, and the pain also gripped him in the epigastrium. X-ray of the gallbladder was negative. He became progressively worse, and the attacks prostrated him, which had not happened on previous occasions. Further x-ray examinations on September 6, 1934, disclosed the condition as previously seen, and indicated that the enlargement was no greater than of three years ago. X-ray therapy was begun, radiating the cervical and thoracic regions. Two series were given to each area as previously outlined in Case I.

On September 23, 1934, following only preliminary treatment, he described certain changes in his condition: the seizures of pain were no less frequent, but the intensity of the pain on each occasion was markedly less, and the duration shorter. He stated that he was able to bear the pain without interrupting his routine. There is one significant finding which should be mentioned here: On every occasion on which we examined him during the past three years his abdominal muscles were markedly tense, almost to the point of rigidity. He was aware of this condition and had at times been annoyed by it, but he attributed it to the fact that he had been a vocalist. He pointed out to us on September 23 that this annoying feature had disappeared, and on examination we found his abdomen soft and relaxed, the first time in three years. On October 6 the patient reported that he had been entirely free from pain during the past ten days.

HYPERTENSION

Blood pressure is dependent upon the size of the circulatory system, the amount of blood, and the force delivered by heart contraction. Success in reduction of blood pressure so far as Deep Roentgen Ray Therapy is concerned depends upon how much the sympathetic system is at fault. The sympathetics can influence each of these three factors in the following way: by contraction of the smooth muscles of the blood vessels it reduces the size of the circulatory system, by stimulating the heart muscles it increases cardiac force and output, by acting on the endocrine system it not only influences the size of the vascular space and cardiac force, but also the amount of blood formed.

When the etiology of hypertension is primarily a sympathetic affair as a result of increased irritability of the sympathetic system, then x-ray therapy has a definite value in the treatment of hypertension. When as the result of prolonged hypertension, calcific deposits occur in the walls of the blood vessels, so that they cannot dilate, and the heart has hypertrophied so that cardiac force is maintained, and the renal vessels are sclerosed so that blood volume remains large, then, of course, x-ray therapy to the sympathetic system will not show such definite results.

If the hypertension is the result of, or is associated with, arterial, cardiac, or nephritic disease, then the results depend upon how much pathology actually exists.

ESSENTIAL HYPERTENSION

Essential hypertension reacts well to deep roentgen ray given along the cervical and dorsal sympathetic ganglia.

Whatever may be the etiological factor producing the irritation of the sympathetic system in these cases, whether it is the result of disturbances in the sympathetic cells themselves, or in the suprarenal, pituitary, or other endocrine glands, deep x-ray therapy seems to remove this irritability and relax the smooth muscles of the blood vessels. Using the cervical and thoracic regions for irradiation makes it possible to depress the sympathetics going to the pituitary and thyroid gland and to depress the sympathetic cells giving rise to the splanchnic nerves which ennervate the suprarenal and other abdominal endocrine glands. Also the majority of vasomotor nerves are depressed by irradiating only these regions. We don't like to irradiate the lower two dorsal or lumbar vertebrae because of the direct depression or permanent injury of the cortex of the suprarenal gland. We feel that irradiating only the splanchnic areas is sufficient to depress the suprarenal gland without injuring the cells themselves. Besides, especially in young individuals, irradiating the lumbar and sacral regions might produce castration and this in itself may be sufficient to raise blood pressure. Likewise we do not irradiate the pituitary gland itself because of possible injury to the brain tissue.

The following are case reports of essential hypertension:

Case IV. G. M., age 36, weight 136, gave a history of having had high blood pressure nine years ago, at which time she was told that her blood pressure was 145/105. She had no cardiovascular symptoms at this time. In the next five years, during which she was resident in Burma, her blood pressure dropped and was recorded as follows:

1927	126/70	1930	100/70
1928	120/80	1931	140/118
1929	125/90		

She has had dengue fever, dysentery, paratyphoid, and has had tuberculous glands removed in 1924. Her father died at the age of 51 of Bright's Disease, and one brother died at the age of 19 of rheumatic heart disease.

In 1932 the blood pressure in the patient's right arm was 170/128, in the left arm, 182/124. There was a short systolic murmur at the apex. Electrocardiogram was negative, and eyegrounds were negative Urine was negative. In April 1934, the blood pressure in the right arm was 200/140, in the left arm 182/138, in the right leg 220/140, in the left leg 200/140. By means of pilicarpin, nitroglycerine, phenobarbital, potassium iodide, and injections of magnesium sulphate, the blood pressure came down to 170/120 in the right arm and 174/120 in the left. As soon as medication was stopped the blood pressure returned to 200/130. There are still no cardiovascular symptoms, but the patient feels tired, has headaches at times for four to five days in succession.

The patient has exophthalmos, widening of palpebral fissure, slight dilatation of pupils. There is a slight systolic heart murmur. Pulse is 90. On July 27, 1934, x-ray therapy was started, and two

series of x-ray treatments were given to the left and right cervical ganglia anteriorly, and upper ten dorsal vertebrae posteriorly, the following factors being used: 180 kilovolts, 5 milliamperes, 40 cm. distance, .8 mm. Cu., and 3 mm. Al. as filters, field of 10 by 15 cm. over the cervical and 20 by 20 cm. over the dorsal regions, 1/3 of a skin erythema dose per field weekly.

After her first series of treatments, the patient's blood pressure went down to 190/132, and after her second series of treatments it was down to 154/90 in the right arm and 140/90 in the left arm. She feels well, and is engaged in very active and arduous work. There is a slight improvement in her exophthalmos, her pupils are slightly smaller. No medication is being given during the course of the x-ray treatments.

On September 16 she developed herpes zoster. We treated the corresponding dorsal segment, giving 1/3 of a skin erythema dose. The pain completely disappeared.

Case V. Patient S., age 44, weight 157, has had headaches, dizziness, ringing in the ears for the past three years. Her menstrual periods are normal, lasting four to five days. Three years ago her blood pressure was 194/110.

PX: Patient has exophthalmos, slight widening of palpebral fissure, and slight dilatation of the pupils. Her heart is negative, her urine is negative. On August 27, 1934, her blood pressure was 210/110, pulse 100. X-ray therapy was started August 27, using the factors as previously outlined. On September 5, 1934, two weeks after the irradiation of only one cervical area, her blood pressure had dropped to 176/96. After one series of treatments to the cervical and thoracic regions her blood pressure dropped still further to 160/90. There is a slight decrease in the width of the palpebral fissure, the pupils are moderately dilated. Her pulse is 78, she feels less dizziness and has no headaches and no ringing in the ears.

HYPERTENSION ASSOCIATED WITH ENDOCRINE DISTURBANCES

Thyroid: That the thyroid is a great stimulator of the whole sympathetic system is shown by the various signs, such as dilatation of the pupils, exophthalmos, rapid heart action, sweating, and increase in blood pressure. This latter also depends a great deal upon the fact that thyroid stimulates the suprarenal glands to greater activity.

In treating the cervical and dorsal area as previously outlined, deep x-ray therapy not only depresses the sympathetics, but actually depresses parts of the thyroid gland, and when the patient has definite thyroid disease we make it a special point to include the entire thyroid gland in the fields. Following is a report on a case of hypertension due to an activated thyroid.

Case VI. Mrs. M., age 56, weight 100, complains of general nervousness, loss of 112 pounds in weight, shortness of breath, for the past year. PX: Shows signs of thyroid toxicosis, exophthalmos, dilatation of pupils, large thyroid, tachycardia, enlarged heart, no murmurs. Wassermann was negative. The urine showed a faint trace of albumin. The basal metabolism rate was plus 74, and her blood pressure was 200/90.

On September 6, 1934, after one series of x-ray therapy had been given to the cervical region, the size of the left thyroid had come down to practically normal. The patient feels fine, is less nervous. Her blood pressure is 152/58, her weight is 114 pounds.

HYPERTENSION ASSOCIATED WITH GONADAL DISTURBANCE

Hypertension is quite often associated with disturbances in the functions of the gonads, and often occurs at the time of the menopause. The mechanism of this increase in blood pressure is not definitely known. It is true that the menopause may produce an increase in weight, and if this is large enough, may greatly increase blood pressure. However, not all people put on weight at the menopause. Some believe that in this latter group the lack of gonadal secretion might produce a disturbance in the endocrine relationship producing hyperactivity of the pituitary and thyroid themselves, which in turn produce an increased blood pressure. A case of hypertension due to disturbance in gonadal secretion was treated by x-ray, and the report is as follows:

Case VII. Patient, M. C., age 54, weight 190, has complained of severe headaches and nosebleeds for the past five years, but gives no other symptoms. She had her menopause five years ago.

PX: The patient's heart showed slight enlargement, but no murmurs. Her urine was negative. On June 8, 1934, her blood pressure was 210/110. On July 13, 1934, after reduction of 31 pounds in weight, her blood pressure was 205/110.

Roentgen ray therapy was started July 27, 1934, irradiating the right and left cervical regions, and the upper and lower thoracic regions; three treatments were given to each area as previously described. Her blood pressure, after one series of cervical treatments went down to the lowest recorded during her illness, which was 182/100. On September 6, 1934, at the end of her second series, the patient's blood pressure was 178/94. On Sep-

tember 20, at the end of her third cervical and first dorsal treatment, her blood pressure was 162/90, and she felt very well.

HYPERTENSION ASSOCIATED WITH CARDIAC AND NEPHRITIC DISEASE

Essential hypertension can cause cardiac and nephritic disease during its course, and it is known that cardiac and nephritic disease can cause hypertension during their course. We believe that whether hypertension came first, or second, the value of deep roentgen ray therapy to the sympathetics depends upon the degree of blood vessel, cardiac, and nephritic disease present.

A case of this type follows:

Case VIII. Patient W., age 53, weight 110. The patient has had heart trouble for the past two or more years, associated with high blood pressure which started eight years ago. She had her menopause three years ago. Two years ago she had a cholecystectomy. The patient, on present admission, complained of shortness of breath, cardiac pain, and edema of the legs. Physical examination showed an emaciated woman, chronically ill. She had a moderately enlarged heart, with a systolic murmur. Her blood pressure was 200/135. Her urine showed an almost fixed specific gravity of 1.012, and there was albumin present.

X-ray therapy was started on July 5, 1934, irradiating the cervical and thoracic regions as outlined previously. After one series of treatments her blood pressure dropped to 162/126. At the end of the second series her blood pressure was 182/127, and at the end of her third series it was 152/90.

In spite of the fact that this case had so much pathology associated with high blood pressure, the x-ray therapy to the sympathetics was sufficient to reduce her blood pressure from 200/135 to 152/90, and to maintain it at that level to the present date.

Case IX. Patient, Mrs. S., age 42, weight 110, had had twelve previous deliveries with no disturbances. During the present pregnancy her blood pressure was normal until the fifth month, when it was found to be 180/110. She became eclamptic at the seventh month, when her blood pressure was 244/104, and her urine showed four plus albumin. Her heart was negative, and her Wassermann was negative. Labor was induced, and the baby was born dead. Two weeks later the patient's blood pressure was 198/119. Her urine was negative for almumin at times, and at other times traces of albumin were found. The nonprotein nitrogen was 33.3 mgm. per 100 cc.

X-ray therapy was started on August 28, 1934, at which time her blood pressure registered 190/110. On September 4th, after one series of treatments, it was 176/90, and on September 6th it had dropped still further to 165/90. When she left the hospital it was 148/90.

In this case blood pressure remained high even a month after delivery, and in spite of the fact that the kidneys were functioning normally; and it was only after x-ray therapy was used that her blood pressure definitely and quickly came down.

HYPERTHYROIDISM

Irradiation has, during the past few years, been used extensively in the treatment of hyperthyroidism and in thyroid toxicosis, and success has been noted by practically all who have done work on this subject. (Pfahler, 17, Holmes, 12, Barclay, 1, Jenkenson, 13, Loucks, 16, Stevens, 19, Ginsberg, 11.)

It is not our purpose here to merely add case reports in support of the usual method of treatment, but rather to describe a new method of treatment. Irradiating the cervical area in the region of the thyroid depresses not only the thyroid cells, but also the cervical sympathetics which some believe are the origin of increased thyroid activity.

Recently Crile[6] has been able to cure by means of adrenal denervation 95.6 per cent of 79 cases of hyperthyroidism in which 51 cases were recurrences or residual hyperthyroidism. This tends to support the theory that hyperthyroidism is really the result of increased activity of the sympathetics sensitized or stimulated by the increased secretion of adrenalin.

If Crile can obtain such excellent results by surgical denervation of the adrenal glands it occurred to us that we might be able to obtain better results than obtained by the usual type of x-ray therapy to the thyroid gland, by irradiating the upper ten thoracic vertebrae which give rise to the splanchnic nerves, which send fibers to the adrenals. Using this method, therefore, we irradiated one of our thyroid patients who had not reacted as well as usual to the routine method of x-ray treatment.

Case X. Patient Mrs. G., age 25, weight 107. She had been ill for the past two weeks with extreme nervousness, tremors, inability to sleep, slight blurring of vision, tachycardia, feeling of nausea. She had had a similar attack five years ago, several weeks after her marriage. This attack lasted seven to eight months.

The patient had exophthalmos, dilatation of pupils, warm skin, flushing of face, rapid heart, 130.

which showed slight enlargement and systolic murmurs. She had tremors of the hands, excessive sweating, a blood pressure of 130/60, and basal metabolism rate of plus 60. The patient did not improve with all the usual medication for thyroid disease.

X-ray therapy was given to the thyroid region. After two courses of treatment her basal metabolism rate came down to plus 30. After another course of treatment it came down to plus 18. However, after the fourth course of treatment the Basal Metabolism again rose to plus 30, and her symptoms which had previously improved, again became aggravated, though not as much as originally. Her blood pressure had come down to 100/30.

We then started to irradiate the nerves leading to the adrenals, that is, the splanchnic nerves. We irradiated the first to the tenth dorsal vertebrae posteriorly, using 1/3 of a skin erythema dose per week. After her first treatment she felt greatly improved. Her basal metabolism rate went down to plus 12, and she has continued to improve during the four weeks which have elapsed since her treatment.

PEPTIC ULCER

The aim of any treatment of peptic ulcer is to put at rest that part of the stomach or duodenum which is the site of the ulcer, so that healing may take place. To do this it is necessary that the muscular movements and the secretion of hydrochloric acid, both of which functions are governed by the parasympathetics or the vagus nerve, be reduced.

However, we do not wish to leave the impression that the parasympathetics are entirely at fault; since Bonnano and Verano[2] have caused a decreased concentration of hydrochloric acid by irradiating the 6th, 7th and 8th dorsal root ganglion, and in this way have caused the stomach to be put at rest.

Crile[6] has also cured 93 per cent of peptic ulcers by denervating the adrenals, the nerve supply of which comes from the splanchnic sympathetics, which are motor to the gland.

At any rate, irradiating the cervical and thoracic regions, whether it depresses the parasympathetics, or the sympathetics, or both, decreases the secretion of hydrochloric acid, and reduces the muscular movements, the effect of which would be to put at rest the ulcer-bearing area, and induce healing of the ulcer. We believe that this method of treatment might be tried in those cases in which medicine fails to relieve the symptoms and in which surgery is difficult or counter-indicated. It may be especially useful in gastrojejunal ulcers.

DIABETES

Insulin is produced not only by the islands of Langerhans, but in all cells, as seen in plant life and in the life of invertebrates. (Tuttle, 21) Carrel's cultures[5] by means of their own cell insulin have used carbohydrates of the solution in which they were immersed.

When as in diabetes the islands of Langerhans are decreased in number, methods are sought by which to increase the insulin-formation in the remaining islands, and to increase insulin-formation in all the cells of the body. In other words methods are sought to increase the sugar tolerance.

The methods used usually involve some therapy to the sympathetic system. Recently DeTakats and Cuthbert[7] have increased the sugar tolerance of the body by denervation of the suprarenal gland, by celiac ganglionectomy, or the removal of the sympathetic nerves to the suprarenal glands themselves. By this method completely depancreatectomized dogs were able to use sugar with no development of diabetes.

Why the removal of the celiac ganglia increases sugar tolerance is explained by, first, vasodilatation of the pancreas causing increased blood supply to the islands. This assumes that it is a vasomotor condition of the pancreas which cause a degeneration of the islands and results in diabetes. That denervation of the adrenal glands raises the threshhold of sugar tolerance has been shown clinically by Crile[6] who has performed this operation many times in the treatment of diabetes. The part the adrenals play in diabetes is not definitely known. It may be that adrenalin acts as a counterbalance to the insulin formed in the cells, Adrenalin causes glycosuria when it is given hypodermically. Denervation of the adrenals causes adrenalin to remain in the adrenals instead of its being poured into the blood stream to prevent the utilization of sugar.

We have irradiated the following case of diabetes coincident with high blood pressure:

Case XI. Mrs. L. R., age 44, weight 201. The patient has had diabetes for four to five years, with all its symptoms. Her blood sugar was 308 mgm. per 100 cc. of blood, and her blood pressure was 200/110. She also had increased pulse and exophthalmos and dilatation of pupils.

On September 2 she began her x-ray treatments to the cervical and dorsal regions, in areas to depress the sympathetics and the nerve supply to the suprarenals.

After her x-ray treatment her blood pressure dropped to 160/90, her blood sugar dropped to 153.8 mgm. per 100 cc., her urine being negative for sugar. She has been sugar-free ever since her treatment. On October 1, 1934, her blood sugar still remained low, being 155 mgm., and her urine was sugar-free. On that date her blood pressure was 136/90.

HAY FEVER, ASTHMA, URTICARIA AND ALLIED CONDITIONS

In allergic conditions in which injections of adrenalin relieve the symptoms by stimulating the sympathetic endings, and in which atropin relieves the condition by paralyzing the parasympathetics, it becomes apparent that, if we could more permanently paralyze the parasympathetics, such diseases as asthma and hay fever, could be more completely relieved. When one considers that these sensitizing diseases can effect every organ in the body, one can readily appreciate the great possibilities x-ray therapy has in the treatment of these diseases.

A case of hay fever was treated by x-ray therapy to the cervical sympathetics. One series of treatments caused a 75 per cent decrease in symptoms.

The following is a report of the treatment of a case of asthma:

Case XII. Mrs. T., age 62. Patient has had asthma for four to five years, and needs from 8 to 10 injections of adrenalin in 24 hours. She has had 13 children, and had her menopause 12 years ago. There is no history of allergy in the family.

A physical examination showed asthmatic lungs, and a slightly enlarged heart. Her test meal showed a total of HCL of 13, and a Free HCL of 0. Gastro-intestinal x-ray series was negative. There was a faint trace of albumin in the urine, and an occasional cast. The blood count was normal. X-ray of the chest showed chronic interstitial pneumonitis.

After two x-ray treatments to her thoracic ganglia the patient's condition has improved to such an extent that she never needs more than two adrenalin injections in twenty-four hours. With further treatments it is to be expected that she will show still greater improvement.

SYRINGOMYELIA

Recently syringomyelia has been treated by deep x-ray therapy. Giese and Ossinskago[10] treated 128 cases with improvement in chief symptoms in 50 per cent, stationary symptoms in 30 per cent, progressive symptoms in 20 per cent. This disease is probably due to a vasomotor disturbance of the cord and brain with subsequent degenerative and cavity formation.

MULTIPLE SCLEROSIS

Multiple sclerosis has been improved by cervico-dorsal sympathectomy (Wetherell, 22). Myelin degeneration in this disease is due to anoxemia of tissue as a result of vasomotor changes. We are treating a patient with multiple sclerosis and will soon have information as to the value of x-ray in this disease.

MISCELLANEOUS CONDITIONS

There are a great many other conditions in which the sympathetic system is hyperactive or the cause of painful sensations. Kuntz[15] gives the result of microscopic study of sympathetic ganglia removed surgically from such conditions as polyarthritis, spastic hemiplegia, progressive muscular dystrophy, and finds signs of chronic inflammation, such as hyperemia, infiltration of the ganglia with lymphocytes and mononuclear cells. He also finds the same conditions in Raynaud's and Berger's diseases. It is a known fact that Deep Roentgen Ray Therapy will cause a sclerosis of the hyperemic blood vessels and also may cause a disappearance of the lymphocytes and mononuclear cells, and in this way remove the source of irritation of the sympathetic system.

Surgical sympathectomies have been used with good results in the following diseases: epilepsy, glaucoma, scleroderma, trophic disturbances, congenital pyloric stenosis, Hirchsprung's disease, and it is possible that x-ray

therapy may benefit these diseases when all other methods have failed.

CONCLUSIONS

We do not wish to give the impression that we have a method of curing all diseases. Without question we believe that deep roentgen ray therapy is especially useful in angina pectoris and other chronic pains caused or transmitted by the sympathetics. It is also especially useful in the so-called essential hypertension, and its usefulness in other forms of hypertension is limited only by the degree of blood-vessel, cardiac, and nephritic involvement. It is of importance in those serious conditions of the central nervous system such as syringomyelia and multiple sclerosis, and in peptic ulcer, and diabetes, and in allergic diseases, the use of x-ray therapy as a possible treatment should be kept in mind.

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A PLAN OF STATE-WIDE MEDICAL INSURANCE ON A CONTRIBUTORY BASIS

By FRANCIS H. GLAZEBROOK, M.D., Morristown, N. J.
Medical Director, New York Stock Exchange

Presented by invitation at the meeting of the Fourth Councilor District of New Jersey at Lakewood, April 3, 1935, and the First District at Newark, May 9, 1935, as a supplement to Dr. Glazebrook's article on "Industry's Contribution to the Cost of Medical Care", published on page 148 of this Journal of March 1935.

There is nothing more dangerous for the medical profession at this time than a state of inertia. I feel that the time has come when the medical profession must act to meet the problem of the cost of medical care. "It is your problem to turn the tide into the current of economic security." To do this, the County Society must work to coördinate all agencies in the communities, and the State Society should be aroused and see to it that any bill presented to the legislature is one agreeable to the profession. "There must be due consideration for, and full recognition of, the fact that the changing era has brought in changing problems, and that the old order of things so long established must change to meet the new challenge and serve the basic interest of the public, the physician, and the voluntary hospital alike. The leadership in thought and action must come from the medical profession." (Bulletin American College of Surgeons.)

There seems to be no doubt that the present method of distributing medical service fails to meet adequately the present requirements, and

that medical service is definitely inadequate to a large percentage of the population; but by the same token, the reward to those who practice medicine is in many cases inadequate, and it is my impression that whatever is done to correct the patient's side of this equasion must also include consideration of the doctor's side.

It does not seem to me that the modern *hospital* accomplishes all that it might. I feel that the voluntary hospital with its equipment and staff would fit very easily into a system of group practice where an individual could go and obtain a complete investigation of the "human machine". "At present, the hospital is a part of an uncompleted equation, the other half consisting of adequate scientific medical service in all branches to all the people, rich and poor, irrespective of their earning capacity."

We cannot deny the fact that *health is a public concern,* and that the state or municipality has a right to act in the public interest. While we of the profession believe that the state's function should be to coöperate through existing agencies, we will have to convince the state that we are prepared to make the necessary adjustments. One of the first steps in this connection is to admit our shortcomings; and next, we should surrender some of the pretentiousness which has been inherited from past generations. We must change our *individualistic* methods for a *coöperative* community organization, and feel that we are colleagues of one another instead of rivals. "The profession must choose between a continuance of the present condition of medical confusion on the one hand, and a political dictatorship over medical practice on the other." (Harper's Magazine.)

It is my feeling that the time has come for the profession to refrain from obstructive activities, and to concern itself with some constructive suggestion. Anything of so serious import as to cause two Presidents of the United States to act—one who appointed a commission to study for five years the cost of medical care, and the other who has appointed a committee to study and suggest some medical plan—should convince the medical profession that it is time to bestir itself. It is far more desirable that the medical profession take the initiative to satisfy this issue, than to be compelled to do so by those outside the profession.

The so-called *Epstein plan,* which is one of the plans suggested by those who are endeavoring to obtain outright state medicine, has been presented for consideration to the various legislative bodies in practically every state in the country. It is, to my mind, one of the most vicious plans that I have seen, and just what the politicians, socialists, and insurance agents are working for. In short, the plan calls for state laws compelling health insurance; and the administration of the plan includes politically-appointed doctors as division heads, and state-wide paneling of physicians under political control. It has been estimated that in a state the size of New Jersey, the administrative cost of this plan would be upward of three-quarters of a million dollars annually. "It would indeed be unfortunate if through divided counsel or inertia of the profession, legislative, or lay action were allowed to decide the destinies of medicine." (Dr. Eugene H. Pool.) The traditions and precedents of the past will amount to naught if the politicians and those back of them once make up their minds to act.

Not for one minute do I presume that there are not men in this Society who have far more ability than I to draw up such a plan; but as nothing of the kind has been offered, I most humbly submit the following suggestions:

LEGAL AUTHORIZATION

I feel very sure that the lawmakers of this state would be most sympathetic to a workable plan for medical care for all of its citizens, agreeable to and proposed by the medical profession of the state.

I am in favor of the state passing such laws and contributing its share of assistance in the cost of medical care, providing that political control is eliminated, and the *Medical Society of the state is given the power of administration.*

CONTRIBUTORS TO AN INSURANCE FUND

I suggest that the Medical Society propose that it be required by law that every individual, single or married, whose income is in the lower brackets, should contribute some amount

every month out of his income toward insurance against sickness. The amount paid by the individual would be negligible.

Each county should be required to contribute to such a fund on some percentage basis of the amount contributed by the individual.

The state should contribute to each county some percentage of the amount contributed by the county, the county and state funds to go toward the care of the indigent and other county work, and to pay the doctors who work in the hospital wards and dispensaries of the voluntary hospitals.

Industrial organizations employing people from among the laboring and clerical classes should be required to make a contribution toward this fund, likewise on some percentage basis of the amount contributed by their employees.

ADMINISTRATION

The County Medical Society together with the County Clerk or County Treasurer should be the custodians of this fund, and the money contributed should be deposited in the several banks in the county in order that all localities may be represented. The clerical assistance necessary to administer this fund should be that already existing in the County Clerk or Treasurer's office. In this way, the administrative cost would be kept at a minimum. That part of the fund contributed by the county and the state should be a fixed expense and part of the annual budget. The Executive Committee of the State Society as chief administrator should be required to set up a schedule of fees including all medical charges for those insured, and this schedule should be consistent with the financial status of the groups insured.

Under this plan, the contributions might be as little as ten cents a week, and no higher than one dollar a week for any individual. Doctors rendering service under this plan will present their bills to the medical committee in the county appointed to pass upon them, and an order for payment will be issued to the county clerk or treasurer.

I believe that a fund of this kind would be ample to meet fully the entire medical cost of those so insured. The doctors would receive fair compensation for all phases of their work, and the amount of work they do will decide their participation in the fund. There will be no danger of graft or of indolence on the part of the physician. The selection of physicians, surgeons, specialists, etc., will be left to the choice of the individual irrespective of his financial status.

For the people whose income is above the insured group, but below the well-to-do class described as Group 4 in my previous article (Jour., March 1935, p. 153), a sliding scale basis of fees should be arranged uniformly on a percentage basis of income. The question of how high up the scale of incomes this plan should be made applicable is one to be definitely determined by those who set it up in its final form. Also to be determined is where the lower limit should be set for those classified as "well-to-do", in order that we may arrive at the middle class or those eligible for fees on a sliding scale basis.

A CONCRETE PLAN

It is always a simple matter to propose a plan and then leave the detail for someone else to work out, so I offer the following as something definite to begin with:

THE SINGLE

A. Single individuals whose income is $1500.00 or under per year should be required to contribute two per cent of their weekly income.

B. Single individuals whose income is over $1500.00 per year should contribute three per cent of their weekly income.

THE MARRIED

A. Married individuals with one dependent whose income is $1500.00 a year or under should contribute two per cent of weekly income. No extra contribution for the dependent.

B. Married individuals with one dependent whose income is over $1500.00 per year but not exceeding $2500.00 should contribute three per cent of weekly income. No extra contributions for dependent.

C. Married individuals whose income is

$2500.00 or more should contribute two per cent of weekly income. No extra contribution for dependent.

Note 1: For each additional dependent in Class A, a flat rate of 15 cents per week should be contributed. For Class B, for each additional dependent, a flat rate of 20 cents a week shall be contributed, and for Class C, a flat rate of 25 cents per week shall be contributed for each additional dependent.

Note 2: If any other member of the family is working or has an income, he or she should not be counted as a dependent, but should pay his or her own way according to the above schedule.

Under this plan, the county's contribution should be 20 per cent of the total contributed by the insured in the county; and the state's share should be one-half the amount contributed by each county.

Industrial organizations should contribute a percentage of the amount contributed by their employees, for it is of interest to industry to be assured that its employees when sick will have good care; the time lost from illness will be reduced, and it will be economically sound for industry to contribute to a plan of this kind.

There is no earthly problem too great for the human mind to solve. All that is necessary is to get at it with the brains available. The medical profession has solved greater problems, and has contributed the brains to do things far more intricate than this seems. I realize that there will be a great deal of detail necessary in preparing a legislative bill of this character, and that I have only touched the high spots in this presentation.

At any rate, it is something to start with, and I have confidence in the ability of the profession in this state to work out the complete details. If anything I have said will help arouse our profession to action, irrespective of whether or not the suggestions I have offered are worthy of consideration, I shall feel happy to have helped.

EDUCATION FOR PHYSICAL WELL-BEING

By William Mather Lewis, A.B., LL.D.,
President of Lafayette College, Easton, Pa.

Abstract of an address before the Academy of Medicine of Northern New Jersey, March 21, 1935.

Our educational system, like all other social structures, is changing in response to the law of supply and demand. Colleges must give the instruction which is needed at any particular time, be it in science, or engineering, or the fine arts, or sociology, or public health. American colleges in colonial times were founded for the purpose of supplying the demand for intellectual leaders, especially clergymen and lawyers. In the early days of the Republic, pioneers from the Eastern States pushed westward, opening new lands in the West, with 3000 persons in covered wagons crossing the Delaware Bridge at Easton during one month in the year 1824. These settlers founded schools and colleges as their forefathers had done in the East, for they were compelled to supply their own demand for trained engineers, and agriculturists, as well as preachers, lawyers, and teachers.

The objectives of the original colleges were as definite as those of football in which, as William James said, the player seeks to carry the ball across a goal line according to definite rules, and against fierce opposition. Knowledge of the game is not enough,—it must be applied to each problem as it arises. The difficulty in education is to translate knowledge into wisdom,—which is applied knowledge. It used to be said that if one has knowledge, he will be safe. It is not noticeable that a knowledge of medicine makes medical students any safer than other students.

Plato taught that education consisted in learning to love what we ought to love, and to hate what we ought to hate. If we can do this, we are educated. But love and appreciation are closely related to the capacity to comprehend and apply the principles of a subject that is studied. A problem in every college and uni-

versity is to determine the aptitudes of the students for the courses which they have chosen, often because they appeared easy or attractive. Boys enroll in engineering courses because they like to take automobiles apart, and yet they may be misfits because they do not like mathematics. An engineering student usually discovers the degree of his aptitude for engineering early in his study while it is not too late to change to a more suitable course. Lafayette at one time had 70 pre-medical students, each of whom thought that he could become a successful happy physician; but nearly a third of them changed their minds when they were subjected to aptitude tests, which included a visit to a dissecting room.

It is a part of education to discover one's aptitude. Psychological tests are valuable so far as they go, for they reveal whether one is apt in handling his mental tools and equipment; or must fuss around in indecision while he seeks the answer to an ordinary problem.

Health is a quality which the college is supposed to develop. An aptitude for health does not always accompany physical strength and robustness. We think of the four years of college life as an era of health. Husky football players are likely to consider health to be a necessary result of their prowess on the athletic field; but other important elements enter into physical well-being. The Athenians were noted for their high mentality and the perfection of their artistic productions. Yet, according to an authoritative writer, the city was short of water; the streets were unpaved, and covered with garbage; and slops were thrown from the windows. Conditions were favorable for plagues which afflicted the people although their marble statues revealed the human body in its ideal perfection.

Every college faces the problem of the health of its students; and is derelict in its duty unless it considers health in all its phases. How can the college give conscious attention to the problem?

1. By a physical examination of every student, and his record kept up to date throughout his college career.

2. By infirmary and hospital facilities, and encouraging, and even requiring, the students to use them. Lafayette teaches the students to acquire the "infirmary habit",—which means that every one with a cold or other minor ailment shall seek the advice of the college physician in the incipiency of his indisposition. The college physician does not tell the student to go back to his work and forget his trouble; but he says, "Report to me at three o'clock tomorrow and I will give you a more definite answer". The boy comes back at the appointed hour, and if he is then all right, he is discharged from immediate observation. One result of the policy is the elimination of contagious diseases which in former years seriously interfered with college work.

3. The athletic field and the gymnasium are utilized for corrective work, especially in the weaknesses following infantile paralysis.

4. Dietetics need attention. A visit to the fraternity houses and eating clubs reveals unbalanced diets,—too much starch, for example, and not enough building foods. It also reveals the need for a dietitian, which is a development for the future.

5. Athletic aptitudes are to be determined; and husky boys with weak hearts are to be kept from heavy exertion which may cripple them. On the other hand, there are intramural sports of all kinds which are adapted to individual abilities and aptitudes. Intercollegiate games center in a small group of boys, while the tendency is to neglect the hundreds of those who do not possess an extremely unusual degree of strength and skill. Lafayette expects every student to learn to play some game, not only for its immediate effect on his health, but also that he may retain an interest in some manly sport when he enters upon his life work.

6. The biggest problem in college education is the emotional life of the student, both in his student days and his after life. Emotional instability often results from the neglect of the education of the emotions through beauty. We have stressed intellectual and vocational development to the neglect of the emotional. Boys come to the infirmary and ask to be allowed to remain there a day or two as a relief from the eternal bustle of activities of college life which allows them no periods

for quiet contemplation and the enjoyment of living. The academic grove has yielded too much to the bustle of the market place. The college should be a power to preserve the soul in peace and to insure emotional stability.

Dr. Henry Sloan Coffin has said that wealth consists in the number and extent of one's appreciations. Playing in the college orchestra, the study of architecture and other fine arts, the abundant use of the library,—these are sometimes called the frills of education, but they are the enduring basis of a stable emotional life. People are on the downward path when they have to hire professional entertainers to make amusement for them. True education develops one's ability to attain satisfaction in his emotional life. A deep interest in some cultural subject is life-saving both physically and emotionally to the business man when he retires from the active practice of his professon and devotes himself to some avocation from the love of it. The real appreciations acquired during college years grow in strength and vividness through the advancing years of life, and promote health in both body and soul.

REPORT OF A CASE OF INFECTED SUB-MAXILLARY GLANDS IN A NEW-BORN

By Frederick H. von Hofe, M.D., East Orange, N. J.

Presented before the Staff Meeting of the Orange Memorial Hospital

The patient represents the mother's first pregnancy. She was delivered May 14th, 1934, at the Orange Memorial Hospital on the service of Dr. A. W. Bingham, at the end of eight months' gestation, delivery being induced because the mother's condition was considered preëclamptic. The infant cried lustily at birth. The birth weight was 3 pounds 9 ounces.

Because of the mother's condition the infant was not put to the breast, but was given a formula. Two weeks after delivery the pediatric department was consulted regarding the feeding of this case. At this time physical examination revealed a small undernourished and underdeveloped infant. There were no abnormal organic findings other than that both submaxillary glands were swollen to the size of medium-sized marbles. Pressure on either gland provoked a discharge of pus from Wharton's duct; and a culture from this pus revealed staphylococcus aureus. The blood count at this time was as follows:

Hemoglobin	100%
Erythrocytes	4,100,000
Leukocytes	10,600
Polymorphonuclear leukocytes	44%
Lymphocytes	54%
Monocytes	2%

The temperature reached 100 May 20th, 101.2 on May 30th, and 100.4 on June 6th. Other than these rises the temperature was at all times within a fraction of 99.

As far as can be ascertained the mother suffered no infection during the period of gestation. Her condition was normal up to just previous to the time of admission to the hospital.

Treatment consisted of nothing more than the daily expression of pus from the glands from the time the condition was first recognized until the 8th day of June when pus could no longer be expressed. From that time on there was no further clinical evidence of any pathology. The infant did fairly well generally, and was discharged from the hospital June 28th weighing five pounds.

THE ANNUAL MEETING

ATLANTIC CITY, APRIL 30-MAY 2, 1935

THE EVOLUTION OF THE MEDICAL SOCIETY OF NEW JERSEY

By Lancelot Ely, M.D., Somerville, N. J.

The Address by the President at the Annual Meeting May 1, 1935, at Atlantic City, N. J.

The Medical Society of New Jersey is holding its 169th Annual Convention here at Atlantic City. As the oldest medical society in the United States, we are proud of our record. The occasion justifies a brief review of our years of growth and achievement.

In the 1760's, under the dominant rule of King George, the people of the American colonies were restive and dissatisfied. The territory west of the Mississippi was still a Spanish possession. The New England settlements were maintained under austere Puritan discipline, hardships being endured with stoic bravery. In Virginia slaves had taken the burden of physical labor from the shoulders of the gentlemen settlers. The West was a closed frontier. Indians were near neighbors to all the colonies and generally hostile to the encroachment of the white man. Daniel Boone was leading exploring parties westward, and the Ohio Valley was being opened for settlement. Except for infrequent stage coach routes, travel was entirely by horseback. In 1766 an express wagon made a trip from New York to Philadelphia in two days, considered a marval of rapidity. Educational facilities were being developed, partcularly in New England, and the earliest colleges had been chartered in the centers of population. In 1764 the first medical college had been founded in Philadelphia. A few newspapers were being published in Boston, New York and Philadelphia, and from these cities were circulated through the country districts.

Throughout the province of New Jersey the progress of New England met and blended with the progress of the South. Its early ownership and government had been unsettled. The successive Indian wars had disturbed its people but little, as the native tribes on this section of the Atlantic coast were weak and timid. Situated as it was between New York and Philadelphia and not too far from Boston and Virginia, New Jersey profited by the advantages of all its surrounding cities.

These, briefly, were the conditions prevailing when seventeen doctors met in New Brunswick at the home of a Mr. Duff and formed our State Medical Society on July 23, 1766. I quote the following account from a contemporary newspaper:

"Narrative of the Rise and Establishment of the New Jersey Medical Society

"The low State of Medicine in New Jersey, and the many Difficulties and Discouragements, alike injurious to the People and the Physician, under which it has laboured, and which still continue and oppose its Improvement in Utility to the Public, and its Advancement to its native Dignity, having for several Years passed engrossed the Attention of some Gentlemen of the Profession, and occasionally been the Subject of their Conversation, it was early last Winter, determined to attempt some Measure for rescuing the Art from that abject Condition (not to say worse) into which it seemed too fast to decline.

"To this End a Legislative Interposition appeared in the first Place greatly to be desired; and an Application for that Favour was proposed; but in this it was necessary to have the Concurrence of the principal Practitioners, and as many other Persons of Weight and Influence as possible; a voluntary Association therefore of such Gentlemen of the Faculty as might approve of the Design, was next projected; a Society of this Kind, it was thought, besides considering of a proper Application to the Legislature, and promoting it most effectually, could in the mean Time take such Measures as were of immediate Importance, and from such voluntary Regulations, as would greatly conduce to the Usefulness and Honour of Medicine, and should the Legislature in their wisdom think it not expedient to interfere, might in a great Degree answer the Purposes of a more authoritative Establishment; not to mention that whether under a Law, or otherwise, a Medical Society well conducted, would naturally derive Credit on the Profession, and ever be of the highest Advantage, both to the Public, and to the several Members. With these good Views the annexed Advertisement was inserted in the Mercury.1"

The Society was a teaching body. Students of law and physic, and sometimes of Divinity were bound by indenture to their instructors. On May 5, 1767, the Society adopted a rule that a medical student should be appointed to a physician for at least four years, one of which might be spent in a medical school "with his master's consent". The fee to be paid to the physician by the apprentice was fixed at one hundred pounds, "being very low, and no more than a bare acknowledgement for board during his term of service". The term *faculty* seems to have been applied to medical societies generally. It first appears in the records of November 7, 1769. The history of the teaching function of the Medical Society is perpetuated in the name "The Medical and Chiurgical Faculty of Maryland", which is still applied to the State Medical Society.

On the day of organization a three-page constitution was adopted. Article seven provided for the formation of "Inferior" Societies, to meet every two months and report their proceedings to the State Society. Four Inferior Societies were at once organized, in Elizabeth, Bound Brook, Princeton, and Morristown.

For several years the formal meetings were concerned chiefly with economic questions. The following report, on November 9, 1773, shows however that science was not neglected:

> The members present entered, as usual, into a free, social, medical conversation, and found a peculiar satisfaction in communicating to each other some cases and observations which have occurred in their practice since the last general meeting.

The first hint of a formal scientific discussion was at the second meeting of the Society, November 4, 1766, when Dr. McKean, President of the Society, communicated a recipe for "dropsies and hysteric cases" which he had obtained from Dr. Ayres, of Newport, Rhode Island, who in turn had received it from Dr. Jared Elliott, of Connecticut. Dr. McKean said he had not yet tried it. The essential ingredient was "Levigated glass, not too fine". The effects he described as follows:

> "If a sufficient dose is taken, there would instantly be felt in the stomack a very severe, pungent pain and an universal shock, something like an electric shock. This would be instantly perceived through the whole nervous system particularly extending itself to the extremities; and if those symptoms did not follow, the dose should then be increased until those sensations were produced."

The record proceeds:

> "The Society, taking the above medicine into consideration, were greatly surprised at the accounts, but judged it not prudent to recommend the use of it, without more authentic proofs of its success."

The first case report to the Society was on November 1, 1785, when the following is recorded:

> "Jacob Probasco, a lad of 17 years, with a tumor in the forearm was brought before the Society for their examination and advice. After due deliberation, the Society were of the opinion that whether it was a tumor of the encysted kind, or an aneurism, incision ought to be made, with a view, if possible, to save the limb; at the same time making every preparation for an amputation if it should be found necessary."

On Wednesday, November 2, a report was made that an operation on the Probasco case had been performed, the tumor extirpated, and found to consist

> "partly of carneous, ligamentous, ossian, and cheesy-like substances, not encysted, but lying within the covering integuments of the arm and occupying the whole space from the cubit to the wrist."

On May 2, 1786, the case was further described to the effect that four days after the first operation

> "the arm was amputated, and at the end of the week, a stiffness of the neck appeared with other symptoms of lockjaw, and notwithstanding warm applications to the part and a free exhibition of opium internally, the symptoms continued increasing, the mouth was obliged to be kept open by force, and a great rigidity of the whole body and limbs took place. In this state he continued with very little remission for six weeks; the wound at the same time (dressed in the common manner) had a good appearance; the symptoms then began to wear away and the cure was performed in eleven weeks. The patient now enjoys good health."

The war of the Revolution interrupted the regularity of the meetings and there are records of none between the years 1775-1781. Then, quoting from a newspaper report:

"A number of the members of the late New-Jersey Medical Society, desirous as well of promoting the science of medicine, as establishing some more regular system of practice in this state, propose restoring the society to its former dignity and usefulness, and will hold their first meeting for this purpose on Wednesday the third day of October next at the house of Mr. Bateman, in Princeton. The former members, and such other gentlemen of the faculty who are desirous of becoming members of this society, are requested to meet there at 10 o'clock in the forenoon.[2]"

And later:

"The members of the late New-Jersey Medical Society are requested to take notice, that at a meeting of a respectable number of members at Princeton this day, (pursuant to an advertisement in the New-Jersey Gazette) it was agreed in to re-establish the Society on its former principals and constitution; and that agreeably thereto, their half yearly meeting, as usual, will be held on the first Tuesday in November next, at this place.

"By order of the Meeting,

"Isaac Smith, Chairman

"Princeton, October 3, 1781.[3]"

Advertisements of the time are interesting to modern readers. From the Pennsylvania Gazette of June 18, 1767:

"The Subscriber begs leave to inform the Public, that he has removed from Burlington to the City of Philadelphia, in Almond-street, a few Doors from the Blue Bell, on Society-Hill, where he proposes to practice all Branches of Physic and Surgery. He undertakes particularly to secure, with small Expense and Pain to the Patient, Cancers and Wens, without cutting them The King's Evil, venereal Disorders, without Sallivation; Rupture, Strangury and Stone; and as he has had great Experience and Success in all the above Diseases, he hopes, by the divine Blessing, to be able to give Relief to any distressed Persons, afflicted with them, that shall apply to him. He takes Patients into his House and boards and lodges them if desired.

"Thomas Wire.[4]"

Another:

"Salem, West New-Jersey, April 19, 1769—

"Twelve Dollars Reward—

"Absconded from his usual Place of Abode, on the 16th Instant, a certain Doctor Thomas Ogle, born in Ireland, about five Feet six or seven Inches high, pitted with the Small-pox, is given to Liquor, and when in Drink talks much of his Skill in Physic and Surgery, has had one of his legs broke, and commonly wears a Handkerchief about it; had on, when he went away, a half worn Beaver Hat, Bearskin Coat, Buckskin Breeches, Worsted Stockings, and good Shoes, with Pinch beck Buckles. He took with him a Silver Watch, a Silver Face, Maker's Name Wm. Clayton, London, No. 2450, rode a sorrel Horse, with a Blaze in his Face; and had a Couple of Boxes, with Medicines in them (like a Pedlar's Pack) and a Suit of Fustian, not made up. Whoever takes up the said Doctor Ogle, and secures him in any of his Majesty's Goals, shall receive the above Reward.[5]"

Another:

"All persons indebted to Doctor Richard Farmer, are requested to pay immediately, and they that have any unsettled accounts with him, are requested to settle them and they shall be discharged, as he purposes going to London directly.[6]"

The following lists interesting old remedies:

"Madeira Wines

"Of the very best Quality. To be sold, by the pipe, quarter cask, or five gallons, by Dr. Atwood, at the house of Joseph Riggs, Esq; in Newark;—also mace, cinnamon, nutmegs, cloves, alspice, &c. Tulington's balsam, Bateman's drops, Haerlem oil, British oil, Anderson's pills, Hooper's pills, Lockyer's pills, James's fever powders, Hill's balsam of honey, a paste for preserving the teeth and gums, Greenough's tincture for the teeth, Boerhagg's balsam, &c. Drugs and Medicines in general. Marble mortars of all sizes.[7]"

The case of John Lawrence, a physician during the Revolution, indicates his position in the community in which he practiced. John Lawrence studied medicine and was graduated from the Medcal College of Philadelphia, receiving the first medical degree conferred in this country. Ten were graduated in this first class, Jonathan Elmer being another member from New Jersey. Dr. Lawrence established his practice in Monmouth County. Early in the Revolution he was suspected of disloyalty to the American cause, was arrested and removed to Trenton. Whereupon

"A petition from sundry ladies at Perth Amboy, setting forth that they apprehend fatal and melancholy consequences to themselves and families, and to the inhabitants in general, if they should be deprived of the assistance of Doctor Lawrence's skill in his profession, as his attendance is hourly necessary to several patients now much indisposed, who will be left helpless if he be removed, as no other practitioner resides in that place, praying that he may be permitted to remain in Amboy."

Gen. Washington answered:

"Unhappily, madam, we are placed in such a situation that motives of consideration to individuals must give place to the safety of the publick. As Dr. John Lawrence therefore has fallen under the

suspicion of our generals, we are under the necessity of abiding by the steps which are taken."

Lawrence was subsequently permitted to leave the state, and settled in New York City until the close of the war, when he returned to New Jersey.[8]

The Revolutionary War proved an impetus to the practice of medicine in this country and brought to the fore three leading American physicians—Drs. Morgan, Shippen and Rush. Drs. Morgan and Shippen were Surgeons General to Washington. Both studied medicine abroad and returned to Philadelphia with a plan to establish a school of medicine. Dr. Shippen initiated and gave a course of lectures on anatomy, and thus laid the foundation for the first medical school in America. Dr. Benjamin Rush fought the yellow fever epidemic in Philadelphia in 1793, and incurred civic and professional hatred by insisting that the disease was not imported from without, but arose *de novo* in the city. He was famed for his teaching ability, and many young men received instruction in medicine under his guidance. Dr. Moses Scott was a physician in New Brunswick, a personal friend and physician to General Washington. He rendered valued service at the battles of Princeton and Brandywine.

Before the general use of vaccination and before much progress had been made in sanitation and prophylaxis, epidemics were very common, bringing death to many. Yellow fever raged, especially in the South, where the only means of disinfecting attempted was the burning of tar barrels in the streets. A so-called inoculation against small-pox was introduced from London, which was claimed to preserve "our fellow creatures from the dismal and fatal effects of that frightful distemper" and under which treatment "there has not Died more than one Person in 700, while in the common way of Infection, 1 dies out of 5".

In the diary of John Hunt, a Quaker preacher of Evansham, near Moorestown, from 1770 to 1800, appears the following entries:

"1777, February 21—There was a distemper seemed to be going about about this time something uncommon it seemed something like a pleurisy mostly beginning in the head and so working down to the stomach of which many were suddenly taken away.

"March 14—At this time my oldest son lay very ill of a fever then very prevalent we heard of burials almost every day and some friends thought it was the same disorder the soldiers died with so fast in Philadelphia. The smallpox and measles began to get about * * *

"March 20—I was confined at home my son Sammie lay ill of a fever that we no ways expected his recovery.

"April 4—I went over into Pennsylvania to a french Doctor for my son Sammie who lay yet very ill.

"April 13—My wife and I went to see William Bates who was now taken down with the small pox and very bad.[9]"

From this account we see there was no idea of quarantine. Hunt reports several visits of mercy to Indian neighbors:

"1777, January 22—I went to see the poor Indians at Edgpiluck there was one Indian woman that had a child just 3 weeks old that morning and she was so well that it seemed as if nothing had ailed her at all—this I could but remark because her cabin was so open. Not so tight and warm as our stables are in common, which under a consideration of the weaklyness of our women at such times caused me to conclude that the more tenderly we kept and nursed ourselves and our children the more tender and weakly we are.[10]"

The Indians had, then as now, their own remedies. Treatments by their medicine men are reported as mostly repulsive hocus pocus, consisting generally of scaring the devils of disease with noises.

There were a few strolling dentists and oculists here and there, but little quackery existed during the Colonial period for the simple reason that no very rich harvest was held out to its practitioners. Witch-doctoring in the sense of averting malign influence was however still common among the Germans in southeastern Pennsylvania. It is reported that the expense account of General Washington for October, 1797, records the payment of $25 to his employee, Christopher, for a visit to a German hex and herb doctor at Lebanon, Pennsylvania, to secure treatment for hydrophobia.

A century ago the 69th "anniversary" meeting was held at William Mann's in New Brunswick. The officers and delegates at that time were: President, Samuel Hays; First Vice-President, A. P. Hagerman; Second Vice-President, Henry Van Derveer; Correspond-

ing Secretary, J. G. Goble; Recording Secretary, P. Vredenburgh; Treasurer, J. S. English; Fellows, A. R. Taylor, J. W. Craig; Delegates: Sussex, David M. Sayres, Stephen Hedges; Essex, Abraham Canfield, Lyndon A. Smith, George Chetwood; Morris, Isaac W. Canfield, Nathan W. Condict, Jeph. B. Munn; Somerset, Ferd S. Schenck, R. S. Smith, Abraham Skillman, Samuel R. Martin; Salem, Charles Hanna; Monmouth, Thomas Greene, Daniel Polhemus, Charles Blauvelt; Burlington, B. H. Stratton.

In 1866, when the Society was 100 years old, the Standing Committee reported the following statistics concerning the physicians of New Jersey: Regulars, 596; Irregulars, male, 130; female, 21. These 151 irregular practitioners are classed: Homeopaths, 58; Eclectics, 31; Not classed, 14; Thompsonians, 6; Quacks, 2; Electricians, 2; Indian doctors, 1; Hydropaths, 1; Botanics, 5; Swedish movement, 2; Inhalation, 1; Cancer doctors, 3; Root doctors, 3; Clairvoyants, 1. The population of New Jersey in 1860 was 672,035, this making one regular physician for every 1251 of population, and one irregular for every 4450 people. The one hundredth anniversary of the founding of the Society was observed on January 24, 1866, in the Chapel of Rutgers College. The President, Dr. Abraham Coles, presided and gave an address of five printed pages and then read an original poem of 45 pages on the Progress of Life from birth to heavenly glory.

The medical profession has met each challenge which has presented itself in all national crisis. The Revolutionary War, which cut the colonies off from Great Britain and its educational advantages, was the opportunity for the beginning of American medicine. After the Civil War the Army doctor continued as the standard by which all doctors were measured. The period of educational awakening immediately following the Civil War affected the medical schools, whose standards were correspondingly raised. The lack of control of epidemics was clearly evident during the Spanish-American War, a situation remedied before the World War, during which epidemics were successfully held in check. It was during the World War that recognition was first given to the Medical Department as an independent service no longer under the control of the line officers.

Many problems of the Medical Society 169 years ago are similar to those facing us today. When on the 23rd day of July, 1766, our great-greatgrandfathers met and organized, the very first item of business considered was the adoption of fee lists. At every meeting for two or three years the subject was considered, then lapsed, to be revived again and again. It is still unsettled. Any of us could enter easily into their discussions regarding non-attendance of members at Society meetings. We see them considering the economic problem which, while acknowledging its importance, doctors have always been reluctant to face. Service is the foundation of our profession. Recompense has always been a second thought. Yet a crisis is fast approaching when the physician must evolve a solution of this pressing problem or he will have a solution forced upon him, one made and presented by authorities who have little knowledge of or consideration for the ethics and point of view of the physician. Recently this situation was considered serious enough for the calling of a special session of the House of Delegates to the American Medical Association, the second such session ever to be called. (The first occurred twenty years ago, when America entered the World War.) We must keep in the front ranks of scientific progress for the proper care of our patients, but must meet and solve professional problems within our organization.

Misleading and false advertising and the misinformation given by cultists and quacks continue a pertinent problem. This must be combated by convincing information given out by reputable physicians. Means of spreading the truth is available to the physician as it is to the advertising agents and should be freely used. We can recall, from early in this century, the campaign against "patent medicines" waged by Bok in the Ladies Home Journal, Samuel Hopkins Adams in Collier's, and Dr. Wiley in his long fight for congressional regulation and control of the purity of foods and drugs. Their success was accomplished only

through coöperation, perseverance, and determination.

Since the turn of this century, greater progress has been made in medical science than in any comparative period in medical history. Study and experimentaton have added much to the knowledge of diseases and their cures. New methods of treatment have been evolved; more efficient control of epidemics has been put into practice; the average span of life has been lengthened. The possibilities for further progress enlarge with each new medical discovery.

In our Medical Society, coöperation promises the fullest achievement in mutual knowledge and efficiency. Let us work together for the further advancement of the Society and our profession.

REFERENCES

1. New Jersey Archives, Newspaper Extracts, vol. VI, page 301.
2. New Jersey Archives, 2nd series, Newspaper Extracts, vol. V, page 293.
3. New Jersey Archives, 2nd series, Newspaper Extracts, vol. V, page 312
4. New Jersey Archives, 1st series, Newspaper Extracts, vol. VI, page 392.
5. New Jersey Archives, 1st series, Newspaper Extracts, vol. VII, page 423.
6. New Jersey Archives, 1st series, Newspaper Extracts, vol. V, page 229.
7. New Jersey Archives, 2nd series, Newspaper Extracts, vol. I, page 196.
8. New Jersey Archives, 1st series, Newspaper Extracts, vol. V, page 432.
9. New Jersey Historical Quarterlies, vol. 52, Diary of John Hunt.
10. Ibid.

TO PRESIDENT ELY

The Seal of The Medical Society of New Jersey represents a priest serving at the altar of Apollo, the god of manly perfection. The President is the center around whom all the activities of the Society revolve. These are the parent ideas from which these verses sprang.

An honored year of fate is thine,
A pontiff at Apollo's shrine
Whence springs the healing art divine.
With pious wisdom, grace, and zeal
That seeks alone your brother's weal
You well personify the seal
Adorning our fraternity.
Revealing what is yet to be
The future lot and destiny
Of all the race of human kind
That gropes with aspiration blind
The supreme happiness to find,
Though unattainable its goal,—
Perfection in both flesh and soul,
In body and in spirit whole.

Your forte it is as President
To speak to every ear intent,
The oracle inspired and sent
With signs and auguries that point
To trends of times far out of joint,
And fallacies that disappoint.
Our wandering thoughts and schemes you guide
Beneath the eddies of that tide
Which flows resistless, deep, and wide
Directing the affairs of men
To ports beyond the common ken
And undescribed by tongue or pen.

Yours too is the prophetic eye
That from the holy mountain high
Elysian fields of life can spy.
Where doctors live in unity,
And patients always pay their fee,
And life is one sweet reverie.

Descend the holy mount to earth
Now in the painful throes of birth
Of cults profane of specious worth,
While in the valley you behold
The votaries of the calf of gold
From idols new and ancient foaled.
Before thy faithful brethren stand;
Give them the true divine command
And lead them to the Promised Land.

Your day has not been one of ease,—
Three thousand doctors hard to please,
Three thousand temperaments appease!
Since you have served your term with grace,
More honored years of toil you face
As in our ranks you take your place,
While your successor carries on
The work by you so well begun,
Forever growing, never done.

—Frank Overton.

PRESIDENT'S INAUGURAL ADDRESS

By Marcus W. Newcomb, M.D., Brown's Mills, N. J.

Abstract of an address given at the Banquet of The Medical Society of New Jersey, on the evening of Wednesday, May 1, 1935, during the 169th Annual Meeting of the Society.

The medical profession is facing critical times. Radical changes in methods of the delivery of medical service are impending, largely because the doctor has been an individualist and has held himself aloof from civic life. The physicians of New Jersey have acted wisely in joining with the dentists, the pharmacists, and the nurses in forming the Con-



MARCUS W. NEWCOMB, M.D.
Inaugurated President of The Medical Society of New Jersey May 1, 1935.

ference of Allied Medical Professions, representing eleven thousand individuals who control one hundred thousand votes,—enough to determine an average Congressional election.

If physicians expect a reduction in taxes, progress in public health, and a higher standard of morals and ethics in public life, they must elect legislators who are in sympathy with these good things. If physicians will act together, they can put honest, fearless men in office; but they will be powerless if they say, "We are doctors and men of science, and cannot be expected to take part in civic affairs."

The cultists attain their desires because they present a united front to legislators. Physicians believe in the triumph of reason; but politicians are swayed by *votes*. A few cultists appealing to their followers can make it appear that the public demand for their services far exceeds that of the patients of scores of reputable physicians who are indifferent to their civic duties.

It happens that for eight years I have had the unusual record of having been a representative of Burlington County in the Legislature, in which it is rare to find a physician, and still rarer, one who possesses a standing and influence that inevitably goes with long service. I am confronted with the responsibility of fulfilling the legislative mission, and I cannot evade it. I can fulfil my duty to The Medical Society of New Jersey in no better way than by promoting wise medical legislation. I can serve the medical profession of New Jersey and the cause of public health best by continuing in legislative activities.

I fully appreciate the honor that goes with the presidency of The Medical Society of New Jersey; but I am also aware that service in the cause of medical legislation is a call to duty which applies with peculiar force to me in this present crisis.

It seems inevitable that I should offer my resignation as President in the near future, in order that the Trustees may be free to provide for the performance of the manifold duties of the office, while I devote myself to the practice of the specialty of medical legislation, unimpeded by professional ties, yet responsive to the ideals and principles of the medical profession.

THE ANNUAL MEETING

The 169th Annual Meeting of The Medical Society of New Jersey was held from Tuesday, April 30, to Thursday, May 2, 1935, in Haddon Hall, Atlantic City. The official registration was as follows:

County	Delegates	Members	Guests
Atlantic	10	63	114
Bergen	17	11	21
Burlington	4	7	11
Camden	6	21	23
Cape May	3	5	1
Cumberland	3	10	6
Essex	49	45	60
Gloucester	3	11	12
Hudson	17	15	17
Hunterdon	2	3	6
Mercer	13	14	16
Middlesex	8	10	13
Monmouth	8	21	14
Morris	4	6	1
Ocean	3	2	2
Passaic	6	6	5
Salem	2	3	5
Somerset	4	9	6
Sussex	1		1
Union	18	16	26
Warren		4	
	181	281	360

Total Number of Delegates	181
Total Number of Members	284
Total Number of Guests	360
Exhibitors	30
Doctors from Other States	18
Total Registration	873

This record is excellent in view of the meeting of the American College of Physicians going on at the same time in Philadelphia and the meeting of the American Medical Association to come five weeks later.

PLANS AND THEIR EXECUTION

The features of the meeting had been planned in greater detail than ever before, owing principally to the resources of the Executive Offices, and the experience of the staff. The execution of the plans was equally satisfactory, with the staff constantly on hand for advice and assistance.

THE HOUSE OF DELEGATES

The business of the Annual Meeting centered in the House of Delegates, which held four sessions. The morning and afternoon of Tuesday were devoted to the discussion of the annual reports of the officers and committees, which were printed in the April Journal, and to the reception of supplementary reports.

All these reports were referred to seven reference committees which held sessions on Wednesday in order to receive suggestions of the members, thereby avoiding disputes and lengthy discussions on the floor of the House.

A session on Wednesday noon was devoted solely to the election of officers, when the present ones were advanced one step in rank, and Dr. William G. Herrman, of Asbury Park, was added as Second Vice-President.

The final session of the House of Delegates was held at two o'clock on Thursday, when the reports of the Reference Committees were received. Most of their recommendations were in approval of the reports, and practically all were adopted by the House.

Late in the course of the meeting an announcement was made of the insistence of the osteopaths on immediate vote on their legislative bill granting them certain rights in practicing medicine and surgery. Dr. Newcomb told of the willingness of the osteopaths to discuss the question of their recognition by the medical profession provided they qualified themselves by taking special courses of study in institutions approved by the physicians, and passing the examinations given by the State Board of Medical Examiners. It is probable that these discussions will result in definite agreements which will raise the standards of osteopathy to conform to those of the physicians; and will be a precedent for dealing with chiropractors and other practitioners under limited licenses. (See page 323.)

The proceedings of the House of Delegates will be prepared and published in the "Transactions" at as early a date as possible, probably as a supplement to the July Journal.

HONORARY MEMBERSHIPS

An honorary membership in The Medical Society of New Jersey was conferred by the House of Delegates upon three members for their long and distinguished services.—Dr. Wells P. Eagleton, of Newark; Dr. Vanderhof V. Disbrow, of Lakewood; and Dr. Philip Marvel, of Atlantic City.

Dr. Eagleton was presented by Dr. Henry C. Barkhorn in a citation which is printed on page 313.

Dr. Disbrow was presented in a brief citation by Dr. James A. Fisher, of Asbury Park. Dr. Disbrow belongs to a distinguished medical family of which notice is made on page 322.

Dr. Philip Marvel, of Atlantic City, Past President of the Society and active in the American Medical Association, was presented in a brief citation by his friend and colleague, Dr. Walt P. Conaway, of Atlantic City.

SCIENTIFIC SESSIONS

There was a good attendance at the scientific sessions, both the general meetings and the sections. The papers were of unusual interest and practical value and will be published in The Journal throughout the year.

The new section on Gastro-enterology was largely attended, and its sessions were continued after the other sections had adjourned,—evidences of the members' interest in them.

SCIENTIFIC EXHIBITS

The scientific exhibits, in charge of Dr. John W. Gray, of Newark, were well prepared and the exhibitors were on hand to explain their salient features. A physician studying an exhibit had the double advantage of seeing the specimens and pictures, and of talking with the exhibitor.

The list of exhibitors and their exhibits was as follows:

1. Wells P. Eagleton, Lewis W. Brown, Carl L. Minier, David McKinnon, Newark: "Tumors of the Brain".
   Description: Mounted specimens and photographic plates.
2. Executive Offices, Trenton: "Organization and Activities of the Medical Society of New Jersey".
   Description: Charts, scrap-books, photographs and the Society Journal.
3. M. J. Fein, Montclair: "General".
   Description: Mounted specimens and photographs.
4. George W. Finke, Spencer T. Snedecor, William K. Harryman, Hackensack: "Useful Fracture Equipment Made in Hackensack Hospital".
   Description: Apparatus.
5. Rita Finkler, Milton Friedman, Newark: "Endocrine Factors in Benign Tumors of the Breast".
   Description: Charts, diagrams, photographs and microphotographs.
6. Angelo M. Gnassi, Jersey City: "Tumors of the Ovary".
   Description: Mounted specimens accompanied by photographs.
7. Samuel A. Goldberg, Newark: "Carcinoma of the Colon and Rectum".
   Description: Mounted specimens and photomicrographs of various types of carcinomata of the colon and rectum.
8. John W. Gray, William G. Bernhard, Cecil H. Gowen, Newark: "Chronic Arthritis".
   Description: Pathology—specimens and microphotographs. Bacteriology—tables, classification, diagnosis and treatment—charts, roentgenologic findings, films and case records.
9. John H. Hoagland, New Brunswick: "New Jersey Formulary" and "Joint Professional Relations Committee".
   Description: Reproduction of formulary with approximately 11 finished products.
10. Bart M. James, Newark: "Kline Slide Tests for the Exclusion of Syphilis".
    Description: Descriptive charts and demonstration of technique for performing the test.
11. G. M. Knowles, Helen Clarke, Geraldine Parry, Hackensack: "Demonstration of Special Diets".
    Description: Charts showing the essentials of various diets, statistical charts and mimeographed copies of food values with mineral and vitamin contents, and trays of food for demonstration.
12. Manfred Kraemer, Maurice Asher, Newark: "The Management of Ulcerative Colitis".
    Description: Charts, x-ray films and drawings to illustrate disease process and management with stress on rest, diet and medication to emphasize the lack of a specific cure.
13. Jacques W. Maliniak, Newark: "Clinical Variety in Plastic Repair of Face and Form".
    Description: Photographs, Negocoll casts and motion pictures.
14. Henry B. Orton, Newark: "Foreign Bodies Removed from Tracheo-Bronchial Tree and Esophagus".
    Description: Various plastic models and approximately 375 foreign bodies.
15. Lyndon A. Peer, Newark: "Skin Grafting and Nose Repair".
    Description: Charts and photographs showing results with various types of skin grafts. Scar contractures of eyelids, axilla, neck and forearm. Loss of lips and eyelid following cancer operation.
16. Hilton S. Read, Atlantic City: "This Medical Mess".
    Description: Charts.
17. R. W. Teaham, W. S. Hastings, E. E. Downs, H. Wammock, Philadelphia: "A Study of Carcinoma of the Cervix Uteri".
    Description: A survey of a group of more than 100 cases of carcinoma of the uterine cervix, showing the histology, gradation, metastases, complications, methods of treatment and results.
18. W. C. Westcott, Robert A. Kilduffe, Atlantic City: "Abdominal Tumors".
    Description: Films, specimens and slides.
19. Charles F. Baker, W. James Marquis, Newark: "Interesting Roentgenograms".
    Description:
20. William G. Herrman, Asbury Park: "Interesting Cases".
    Description:
21. William Wallace Mayer, Jersey City: "Pyloric Cap Deformities".
    Description: X-ray films.
22. Louis L. Perkel, Edgar Burke, Jersey City: "Cholecystography and Biliary Calculi".
    Description: About 100 cases of gall-stone correlated with cholecystographic findings, normal cholecystograms, calcified gall-blad-

ders, poorly functioning gall-bladders and examples of source of error in interpretation of cholecystograms.

23. Raphael Pomeranz, Newark: "The Mesentery". Description: Radiologic studies.

24. George S. Reitter, East Orange: "Interesting Bone Lesions". Description: Films.

WOMAN'S AUXILIARY

The Woman's Auxiliary had its own headquarters, which were furnished as lounging rooms where the ladies were assured of companionship and rest between the sessions.

The business of the Auxiliary was transacted in two sessions. The project of the Speakers' Bureau was discussed and plans were made for its further deevlopment. (This same project also received the approval of the House of Delegates).

The Woman's Auxiliary were sponsors of the Art and Hobby Exhibit, with Mrs. H. D. Corbusier, of Plainfield, Chairman. The list of exhibits will be published in the June Journal.

THE BANQUET

A banquet of the State Society was held on Wednesday evening with over three hundred persons in attendance. The after-dinner program was official in that the annual Presidential Address was delivered by Dr. Lancelot Ely, and the inaugural address of the incoming President was given by Dr. Marcus W. Newcomb.

These addresses appear on pages 303 and 309 of this Journal. The address of Dr. Ely was broadcast over Station WPG of the Columbia Broadcasting System.

Dr. Carrington's introduction was as follows:

"This broadcast is coming to you from the Rutland Room of Haddon Hall in Atlantic City, New Jersey, over Station WPG. Here the doctors of New Jersey and their wives are attending the 169th Annual Meeting of The Medical Society of New Jersey. The ornate room is banked with flowers; an audience of three hundred serves as a sounding board for a far greater invisible audience, the President of the Society and his charming wife guests of honor.

"The President of The Medical Society of New Jersey was born in the sleepy village of Dover, from which sleeping powders derived their name. He moved from Dover to make a name for himself because he did not like the name Lancelot which they gave him. He received his medical degree in Baltimore and went back to Flanders to practice. His operations were successful, but in Flanders' fields the crosses grew row on row, so he moved to a suburb of Somerville. Now a suburb of Somerville is two blocks in any direction from the Court House made famous by the Hall-Mills case. If you have any difficulty in remembering the name Somerville, remember Slim Somerville!

"Our President is married and has four delightful children. He has two hobbies,—collecting rare Indian relics, and rarer professional fees as a reward for his surgical skill. He was awarded a fellowship in the American College of Surgeons. He helped win the War, entering as a Lieutenant, emerging as a Major, and now is a Colonel.

"His year as President of The Medical Society of New Jersey has been a notable one. His leadership has been a real contribution not only to the medical profession of New Jersey but also to the public at large.

"Sir Lancelot and his lady Elaine have brought us the gracious charm of the Round Table. I have the honor of presenting to you the distinguished President of The Medical Society of New Jersey, a worthy successor to an unbroken line of illustrous predecessors, Dr. Lancelot Ely."

The toastmaster and general director of the Banquet was Dr. William J. Carrington, of Atlantic City, whose position as head of the Kiwanis Clubs of America is a guarantee of his qualifications, while four pages of song parodies from his pen were indications of his ready humor.

A feature of the evening was the reception of supposedly radio announcements from Somerville, the home of President Ely, with congratulatory addresses from the local politicians, chiropractors and medicine vendors.

An entertainment was staged by M. Rossini, Miracle Master, who mystified the most sophisticated doctors, and after the seance confounded them still more by his alleged explanations of how he did his impossible tricks.

Dancing ended a perfect evening of entertainment.

SECRETARIES' AND REPORTERS' DINNER

A dinner meeting of the County Secretaries and Reporters was held early on Tuesday evening, at which the following program was carried out:

Content and Value of a County Society Bulletin

Ralph K. Hollinshed, Gloucester County
Hammell P. Shipps, Burlington County

Discussor: Frank Overton, Editor

How a County Medical Society May Prepare, Issue and Pay for a "Monthly Bulletin"

Thomas McG. Brennock, Hudson County

Discussor: F. Edward Whitehead, Bergen County

State and County Medical Society Functioning and Suggestions for More Cohesive Performance
Robert S. Gamon, Camden County

Discussor: Frank W. Pinneo, Essex County

What Are the Qualifications for a County Society Membership? Active, Associate, Honorary

General Discussion
Leader: Robert A. Kilduffe, Atlantic County

There was a general appreciation of the work of the Reporters in sending news to the State Journal, since the reports revealed the attitudes of the local societies toward the activities and projects which were common to all. The State officers also expressed their satisfaction with the accounts of the activities of the County Societies.

It was voted to hold the next meeting at the time of the State Society meeting rather than during the middle of the year when the members would have difficulty in coming together.

COMPARISON WITH LAST YEAR

There was some fear expressed that the early date of the meeting of the State Society, the meeting of the American College of Physicians at the same dates as the State meeting, and the coming meeting of the American Medical Association would distract from interest in the State meeting.

There was no lack of interest and enthusiams at the State meeting.

There was a record attendance at the 1934 meeting, but that at this year's meeting compared favorably with it, as is shown in the following table:

	1935	1934
Delegates	181	200
Members	284	349
Guests and visitors	408	422
Total	873	971

This table demonstrates that The Medical Society of New Jersey is a complete unit in itself, capable of carrying on its own independent life and action.

NEWSPAPER PUBLICITY

The major duty assigned to the Editor was that of meeting the newspaper correspondents. The public appeal of the meeting is shown by the fact that the reporters came every morning and afternoon, and that their reports were extensively used by the metropolitan newspapers of New York and Philadelphia.

Press releases had been prepared showing the civic activities of the Medical Society and these were quoted by the newspapers; but the reporters depended largely on interviews of the speakers to whom they were introduced. The newspapers treated the Annual Meeting with respect and consideration.

It was surprising how many scientific articles had a public appeal; and how well informed the reporters were on all phases of medical service. Educated people know what good medical practice is, and are hungry for more information. It is the duty of the medical profession to supply the demand.

RADIO BROADCASTS

Station WPG of the Columbia Broadcasting System, Atlantic City, was generous in its offer of its services to the physicians. Radio talks were given every afternoon by Dr. W. P. Eagleton, Dr. Stanley Nichols and others. That by Dr. Eagleton is printed on page ... of this Journal.

The Presidential Address of Dr. Ely was broadcasted by the system, which gave a half hour to the program of the Doctors' Banquet on Wednesday evening. (See page 303.)

WELLS PHILLIPS EAGLETON

Citation as Honorary Member of The Medical Society of New Jersey, April 30, 1935

By Henry C. Barkhorn, M.D., Newark, N. J.

Doctor, Author, Philosopher, Teacher, Sociologist, but above all, Humanitarian and Friend of the Doctor! From his earliest youth his interest in people was so manifest that his mother and friends remarked on the fact. His entire philosophy of life has been centered around the thought of loyalty to those who, by their efforts, showed that they were thinking for the good of humanity and the welfare of his chosen profession.

Past President of a half dozen local and national societies and agencies, his ambition has always urged him onward in helpfulness to the younger man and has given him a vision of the social needs of mankind. A cosmopolitan in his point of view with both a national and an international reputation as a scientist and surgeon, he has always presented an outline of his findings to his fellows in this State before disseminating them at large. Because of this, appreciation of his broad learning can best be demonstrated by the esteem and regard we, his professional colleagues, show him.

A fighter for the right, he has been much sought after as a speaker before professional assemblages here and abroad. He has often, at great personal sacrifice, traveled long distances to spread his knowledge, both scientific and social, thus endearing himself to his multitude of friends and fellow workers. Busy taking care of many seriously sick patients from near and far, he has found time to write over 60 articles and two books, both of which were translated into French; and when the call to service came he immediately enlisted.

It has been aptly said of Dr. Eagleton, "If we had more men like you to hand down the old Hippocratic tradition from one medical generation to the next, we should not have to be afraid of commercialization of our profession." His effort, in season and out, through example and precept to keep the medical profession moored to its high calling, his tremendous energy in stimulating and encouraging the spark of idealism show how much we need him as a staunch warrior to battle on behalf of the profession in these troublesome times. To quote Dr. Eagleton, "The spirit of medicine is greater than any one man's spirit; it is the accumulated spirit of ages of unselfish service. This is our heritage."

We are proud to know a man who is thus holding high the torch for us to follow. In honoring him we honor ourselves. For the Committee on Honorary Membership I present the name of our own Dr. Wells P. Eagleton.

BIOGRAPHY

Wells P. Eagleton, Specialist in Ophthalmology and Otology and Cranial Surgery.

Born Brooklyn, N. Y., Sept. 18, 1865, licensed, 1888, N. Y., N. J. School education, Brooklyn Polytechnic School; medical education, Columbia U. College of Physicians and Surgeons, M.D., 1888, internship, Newark City Hospital, 1888-90. Newark Eye and Ear Infirmary, 1890-91. Entered World War 1917, served as Chief of Dept. of Surgery, Camp Dix, 1917-18; Colonel, M. O. W. W. R. C.; Member Board for the Amelioration of the Conditions of the Blind, State of N. J., 1914-18. Medical Director and Sec'y, Board of Trustees, Newark Eye and Ear Infirmary; Chief of Division of Cranial Surgery, Newark City Hospital; Attending Cranial Surgeon, Presbyterian and St. James Hospitals; Consulting Surgeon, Hospital for Women and Children and Newark Memorial Hospitals; Consulting Cranial Surgeon; St. Barnabas, Orange Memorial (Orange), Irvington General (Irvington), St. Michael's, Mountainside (Montclair), Newark Beth Israel and Muhlenberg (Plainfield) Hospitals and Elizabeth General Hospital; Consulting Ophthalmologist and Otologist: Hospital and Home for Crippled Children, Essex County Hospital for the Insane (Cedar Grove), Morristown Memorial Hospital (Morristown), and Essex County Hospital for Contagious Diseases (Soho). Trustee of Welfare Federation of Newark and Newark Museum; Past Pres. of the Newark Council of Social Agencies; formerly, Director of the Federal Trust Co. of Newark. Author of textbooks, "Brain Abscess" and "Cavernous Sinus Thrombophlebitis" (both translated into French), and numerous professional articles on cranial surgery.

Member: American Laryngological, Rhinological and Otological Society (Past Chairman, Eastern Section); American Otological So-

ciety (Past Pres.); N. Y. Otological Society (Past Pres.); Practitioners' Club (Past Pres.); Essex County Medical Society (Past Pres.); Medical Society of N. J. (Past Pres.); American Medical Assn.; Fellow, American College of Surgeons (Member, Board of Governors).

Member of Academy of Medicine of Northern New Jersey (Past President): Present Chairman Board of Trustees of Medical Society of New Jersey. Present President of American Academy of Ophthalmology and Otolaryngology.

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WHAT THE MEDICAL SOCIETY OF NEW JERSEY HAS ACCOMPLISHED FOR HUMANITY IN THE 169 YEARS OF ITS EXISTENCE

By WELLS P. EAGLETON, M.D., Newark, New Jersey
Chairman of its Board of Trustees

A Radio Address given on the afternoon of Tuesday, April 30th, 1935, over Station WPG of the Columbia Broadcasting System, Atlantic City, New Jersey, during the Annual Meeting of The Medical Society of New Jersey.

There is now in session at the Hotel Haddon Hall, in Atlantic City, the oldest Medical Society in existence on this Continent—The Medical Society of New Jersey—composed of the regular licensed physicians of New Jersey, this being its 169th Annual Meeting. For in 1766,—ten years before the signing of the Declaration of Independence,—a group of physicians practicing in New Jersey met and then formed the first State Medical Society in the United States.

Their professed objects were "mutual improvement"; the "advancement of the profession", and the "promotion of the public good"; and in their call they said: "and being desirous of cultivating the utmost harmony and fellowship of our brethren, we invite every gentleman of the profession in the Province to attend our first meeting"[1] (for New Jersey was then a province of the British Crown).

In these few words, the whole trend of practice in the healing art, not only for New Jersey but for all the states, was formulated: "mutual improvement", *not* financial privilege; "the advancement of the profession", *not* the exploitation of the individual"; the promotion of the public good"; and "every gentleman" of the profession invited to attend. For one of the essential traits of a true physician is that he have the character of and act the gentleman.

This, the original concept to guide the conduct of the regular physicians in New Jersey, was formulated eighty-one years before the American Medical Association was organized. From that code of ethics the medical profession, as typified in The Medical Society of New Jersey, has not deviated.

At the time of its formation there were no restrictions regarding the practice of medicine. Any man who wanted to advertise himself as a healer, could do so, *but he could not become a member of The Medical Society of New Jersey*; as it early required that no one be admitted who was not a Doctor; who had not had an apprenticeship in medicine of less than three years. This was the first prohibition placed upon Doctors of Medicine by any state group which is now in existence in the United States.[2]

Years afterward, in 1847, the American Medical Association was formed, and many years later, in 1890, the first Medical Practice Act was enacted,[3] preventing any one from practicing medicine excepting those licensed by the State; and year after year this prohibition has become more and more stringent.

Today, to obtain a license to practice medicine in New Jersey, the applicant must be a graduate of a high school after four years' attendance, and then have attended an academic college for two years; must pass four years in a Grade A medical college, which confers on him a degree of Doctor of Medicine; and then he must serve as an intern for at least one year in an accredited hospital. Having met all these requirements, the applicant for license is admitted to an examination by the Board of Medical Examiners. No one can become a member of The Medical Society of New Jersey who does not possess all these requirements.

Think of what is necessary to become a Doctor of Medicine and then to obtain a license to practice in New Jersey—eleven years devoted to study after leaving preparatory school, and seven years, after graduation from high school.

Every now and then, for personal reasons, an effort is made to nullify these prohibitions built up by The Medical Society of New Jersey for the protection of the public. Today there is a bill, which has passed the Senate, giving a man who has not been graduated from an accredited school of medicine an opportun-

ity to appear before the Board for examination. Those advocating this do not know that they are striking at the very heart of legislation designed for the protection of the public; for if we permit entry to medical practice through the back door, we would soon have the profession crowded with charlatans and the public would be at their mercy.

But the chief pride of The Medical Society of New Jersey does not lie in what it has done directly, but in what it has accomplished indirectly, by stamping *its thought* and high line of conduct for mutual improvement by *non-competitive achievement*, on all true physicians. For by its ethics, no doctor can patent any discovery or device, or advertise himself or his individual work and still remain a member of The Medical Society of New Jersey. What he invents belongs to all; what he accomplishes is for the benefit of all.

In 1845, the New Jersey Lunatic Asylum Act was passed and the first Insane Asylum in the State was established. This was achieved only after The Medical Society of New Jersey had memorialized the legislature and successively demonstrated the need for such an institution for seven years, that is from 1838.

And so our great State institutions, in which we take such pride, had their origin in the efforts of The Medical Society of New Jersey,—institutions manned for years largely by physicians receiving little or no compensation, manned by doctors whose ethics called for the promotion of the public weal.

In a similar way, every hospital in this State was founded and operated by physicians who adhered to these ethics. And today, as we view our magnificent hospitals in every city of the State, with their large annual budgets obtained by Community Chest drives, we should recall that these are but superstructures, made possible by physicians striving to fulfill a principle enunciated in the "Fifth Article of the Constitution of The Medical Society of New Jersey" in 1766, which states:

"As we have separated ourselves to an office of benevolence and charity, we will always most readily and cheerfully, when applied to, assist gratis, by all means in our power, the distressed poor and indigent in our respective neighborhoods, who may have no legal maintenance and support from their County; but where such legal provision takes place, there we shall expect a reasonable reward from the particular town or county to which such poor may belong."

In 1847, The Medical Society of New Jersey "urged that the different churches . . . instruct their sextons to report the number of funerals in their various burying grounds". Out of this grew the State Board of Health,[4] the establishment of which was largely due to the efforts of The Medical Society of New Jersey, and whose activities have eradicated typhus fever, cholera, smallpox, typhoid fever, and now diphtheria.

For in 1877, the Society called the attention of the Board of Health to the necessity of taking steps to prevent the spread of smallpox; and in 1884, it took similar action to prevent the contagious eye disease of infants—the ophthalmia of the new-born,—which formerly caused blindness or defective vision in hundreds of infants, cases of which filled our eye clinics only forty years ago. All such cases have now disappeared because of measures taken and the laws enacted through the instigation of The Medical Society of New Jersey.[5]

But you will say "all these achievements simply apply to New Jersey, to its hospitals, its institutions, its health, the code of ethics of its doctors"; but my title is "What The Medical Society of New Jersey has Done for Humanity", and fortunately all humanity is not in New Jersey. But every practical achievement when given to the world helps all humanity; and because of the efforts of The Medical Society of New Jersey to secure a pure milk supply for the people of this State, world-wide benefit was derived.

Dr. Henry Coit, of Newark,[6] in the early nineties, utilized the observation that the milk in a cow's udder never sours, that what causes it to sour is contamination by bacteria entering during or after milking. With this in mind he elaborated a routine for the selection of cows, and for aseptic milking and bottling of the milk. The enforcement of his plan he put under the control of Medical Commissions,

—County Commissions for Certified Milk—commissions of doctors serving without remuneration; and his scheme has spread all over the world, and today as an outgrowth of the labors of a New Jersey doctor the world is supplied with milk that is not only pure but will remain so for a considerable length of time. Thus, without a penny of compensation for himself or his brethren, he conferred a blessing on humanity, saving and prolonging the lives not only of infants but also at all ages and in all walks of life.

This startling permanent contribution for the good of humanity was made by a Doctor; and because Dr. Coit was a member of The Medical Society of New Jersey, and conformed to its ethics, no patent or limitation was placed on its application.

For the practice of medicine is more than a means of livelihood; it is a course of service. Its ethics have prevailed among regular doctors since the time of the Greeks, its ethics were brought to these United States by our Anglo-Saxon forebears. Its ethics have prevailed because they are for the greatest good to humanity.

Today the medical profession is the only one of the professions whose ethical standards are enforced. As a President of the Society wrote:[7]

"We are ethical because we are on duty and need the drill and decorum of a well-equipped corps, and need that stragglers and deserters be kept outside the lines in order that we may do the most good and effective service for the public weal."

Today, in the general economic chaos, when the masters of economic life have proved themselves ignorant, incompetent, and callous; today, when the best legal talent is too often devoted for escape from public responsibility, enabling wealth to avoid paying income taxes and showing it how not to be legally culpable although patriotically contemptible; today, when the Government is compelled to stop the sale of securities known by the insiders to be worthless, securities fostered by men in high places;—today, when there are no ethics enforced against the selfish rich, excepting for the technical violation of a law; today, when gross materialism sways men's action, The Medical Society of New Jersey continues to enforce its ethical standards. It is still organized for "mutual improvement", not personal exploitation; for the "advancement of the profession", not of the individual; and for the "promotion of the public good"; and it still demands that its members be "gentlemen".

REFERENCES

1. Eagleton, Wells P.: Memorial to the late Robert McKean, M.D., Address of Dedication, at the presentation of a tablet by The Medical Society of New Jersey to St. Peter's Church, Perth Amboy, N. J., on the 225th anniversary of its founding, on Nov. 4, 1923.

2. From 1772 to 1851 the licensing of practitioners was practically in the hands of The Medical Society of New Jersey. In 1851 and 1854 the law exempted the graduates of the regular medical colleges from supervision by the Society. In 1864 this Society voluntarily surrendered all its special privileges, although its constituent Component Societies retained the right to confer the degree of Doctor of Medicine. The law of 1880 required filing of diplomas from the Society or from a regular medical school with the County Clerk. See English, David C.: Our Medical Society; Its Past Success, with Some Suggestions Concerning Its Future Usfulness, Trans. Med. Soc. New Jersey, 1895, page 178. Dr. English began his address with "My love for this Society, veneration for its grand history and the earnest desire for its perpetuation . . ." Dr. David C. English, born in 1841; died in 1924. Served in Civil War; President of Medical Society of New Jersey, 1897; Founder and Editor of the Journal of the Medical Society of New Jersey. Wells P. Eagleton: Memorial to the Late David Combs English, M.D. Address of Dedication of Tablet Placed by The Medical Society of New Jersey in the Presbyterian Church at New Brunswick, N. J., on May 15, 1927.

3. Passed through the efforts of Dr. James T. Wrightson. Newark, N. J.; born 1853, died 1927. President, Essex Co. Medical Soc., 1902. See "Some of the Needs of the Medical Profession in Essex County." Address of the President, Wells P. Eagleton, at the Annual Meeting of the Essex County Medical Society, Apr. 6th, 1909, Jour. Med. Soc. of N. J.

4. The society memorialized the legislation in 1848. A supplement to the registory law was passed in 1851. The Society continued its agitation for further action until 1873-4, when after the work of its Committee on Public Health had been emphasized during an epidemic of cholera, the legislature enacted the formation of a commission, the State Board of Health being established on May 17, 1877.

5. Law passed in 1895 largely through efforts of Dr. Chas. J. Kipp; born 1839, died 1911. Surgeon, U. S. A., during Civil War, 1865. Established first eye and ear clinic in New Jersey at St. Michael's Hospital. Founded Newark Charitable Eye and Ear Infirmary in 1880. President of Medical Society of New Jersey in 1886, when he organized its Society for Widows and Orphans of Medical Men.

6. Dr. Henry Coit; born 1854, died 1917. Founded Babies' Hospital of Newark which later became the Coit Memorial Hospital.

7. Dr. William Elmer: President of Medical Society of New Jersey in 1860.

THREE GENERATIONS OF PHYSICIANS

THE DISBROW FAMILY



Dr. Stephen Morgan Disbrow
1812-1894
General Practitioner, Consultant and Author.

Dr. Vanderoff M. Disbrow
born 1857. Honorary Member of The Medical Society of New Jersey, April 30, 1935.

Dr. Harold B. Disbrow
Born 1889. Surgeon, and Trustee of The Medical Society of New Jersey.

Three generations of physicians are worthy of note, especially when they are outstanding leaders. The Disbrow family of Monmouth and Ocean Counties has produced seven physicians during three generations, of whom two are still in active practice.

The line of physicians began with Stephen Morgan Disbrow, who practiced in Farmingdale and its vicinity for sixty-one years. He was born in Brooklyn, N. Y., on October 2, 1812, and died June 2, 1894. He graduated from the College of Physicians and Surgeons in 1834. He was a great reader of medical literature and frequently contributed papers to his Medical Societies. He was in great demand as a consultant and was a recognized leader in his profession.

An account of the life of Stephen M. Disbrow appearing on page 266 of the Transactions of The Medical Society of New Jersey of 1894, states:

"Dr. Disbrow was the father of nine children, six of whom survive him. Five of his sons were physicians, four still are practicing, Stephen and Vanderoff M. at Farmingdale, while Lefferts and Clarence are located at Toms River."

Dr. Vanderoff M. Disbrow, one of the five medical sons, is still practicing medicine in Lakewood. He was born on April 22, 1857, and graduated from the University of Vermont in 1880, and has practised in Farmingdale and Lakewood for fifty-five years. He is still hale and hearty, and was given special recognition by the Fourth Councilor District at its meeting in Lakewood on April third. He was made an honorary member of The Medical Society of New Jersey on April 30, 1935.

Dr. Harold B. Disbrow, son of Dr. V. M. Disbrow, was born on July 7, 1889, and graduated from Princeton 1911, and from Johns Hopkins Medical School in 1916. He served in the World War with the 29th Division as captain in Medical Corps. He is a Fellow of the American College of Surgeons, Surgeon and Chief of Staff to the Lakewood Paul Kimball Hospital, and a Trustee of The Medical Society of New Jersey.

The Journal will be ready to publish accounts of other families which have produced three generations of physicians. A century or more ago, when medical instruction was given largely through personal contact with a preceptor, it was natural that the sons of physicians should not only inherit the characteristics which make a successful practitioner, but also should learn the art by direct observation of their father's work. The memory of these families should be perpetuated.

STATE SOCIETY ACTIVITIES

LEGISLATION

A joint meeting of the Board of Trustees and the Welfare Committee of the New Jersey State Medical Society with representatives of the New Jersey State Osteopathic Association was held on the evening of May 6th, 1935, at the Executive Offices of the State Society, 137 East State Street, Trenton, New Jersey.

President Newcomb stated that this meeting was called to consider the report of Mr. Richman, Consulting Attorney to the Committee on a Uniform Medical Practice Act, regarding a committee substitute for bill A-238, which provided for a sweeping extension of the field of practice by osteopaths. The original bill provided that the extended privileges should be granted to all osteopaths; but after a conference of the physicians with the osteopaths, a substitute for the bill was introduced, limiting the extended privileges to those who qualified themselves according to the standards of the Medical Profession.

The House of Delegates of the State Medical Society considered the substitute bill on April 30th, and referred it back to the Welfare Committee and the Board of Trustees, with authority to consult legal counsel in regard to the implications of the bill.

The meeting on May 6th was held in response to the action of the House of Delegates, with about thirty members of the Board of Trustees and the Welfare Committee present. There were also present the attorney of the New Jersey State Osteopathic Association, and three representatives who had been empowered to enter into agreement with the State Medical Society.

The representatives of the osteopaths stated that they were in full accord with the attitude of the State Medical Society, and would agree to support a bill which would grant the privileges of practicing medicine and surgery to those osteopaths only who could qualify themselves by special courses of study and by passing the examination of the New Jersey State Board of Medical Examiners in therapeutics and surgery.

Attorney Richman had made a careful study of the legal aspects of the substitute bill, A-238, and stated his opinion that it did not provide a short-cut for anyone to obtain a license to practice medicine, and that it would not interfere with the adoption of a Uniform Medical Practice Act in the future.

On returning to the Legislature later in the evening Dr. Newcomb reported the agreements to the Committee on Public Health, of which Dr. Bien of Essex is Chairman, and to which the committee substitute for Bill A-238 had been referred; and the committee at once voted to support the bill.

The bill came to a vote in the Assembly on Tuesday afternoon and was passed unanimously. It will come up for vote in the Senate on the evening of Monday, May thirteenth, and there is every indication that it will be passed.

LEGAL FORMS UNDER THE PHYSICIANS' LIEN LAW

The following instructions for filing and cancellation of lien under Chapter 146, Pamphlet Laws 1935, the forms of lien claim to be filed, and the cancellation form, have been received from Senator Sedgwick Rusling Leap, Attorney for The Medical Society of New Jersey in drafting the Physicians' Lien Law:

Notice in writing containing the name and address of the injured person, date of the accident, location of accident, name of physician, name of person, firm or corporation alleged to be liable for the damages, if ascertainable, is to be filed in the office of the County Clerk in the County in which the injuries occurred, prior to the payment of any moneys to the injured person or his legal representative, in no event later than ninety days after the accident.

Within ten days of the filing of the notice, the physician is to send, by registered mail, a copy of the notice, with a statement of the date of the filing of the lien, to the injured person and to the person, firm or corporation alleged to be liable for damages, if the name and address of the person liable can be ascertained. Upon failure to send copies of this notice the lien is void.

The County Clerk is required to provide a book called the *Physicians' Lien Docket*. The Clerk is entitled to a charge of twenty-five cents for filing the notice of the lien. He is also entitled to a search fee of twenty-five

cents. (The physicians, of course, would not be interested in this.)

The physician is required to discharge the lien when he has been paid; the exact language being "The physician to whom such lien has been paid shall file in the office of the Clerk where the notice was filed a duly acknowledged certificate to the effect that the lien filed by said physician has been duly paid or released, and authorizing the Clerk to discharge the lien. The physician is required to send a cancellation fee of ten cents with this certificate".

"Any physician filing lien shall, within ten days of the receipt or request from any party alleged to be legally liable or against whom the claims has been filed, or at the request of any duly authorized representative of the above parties, send to the parties so inquiring, a statement of the injuries sustained by the injured person, and an itemized statement of the charges and services rendered to date. On failure to comply with this request, the lien is also void. Protection of the physician is accomplished by reason of the fact that any person making settlement is required to withhold twenty-five per cent of the amount of any claim, cause of action or judgment. The physician is given the right, at any time within a year from the time of the settlement of such claim, to bring his suit against the party making the payment."

Senator Leap suggests that the proper form of the lien to be filed shall contain the following items of information:

1. Name and address of injured person.
2. Date of accident.
3. Locality in which the accident occurred.
4. Name of physician.
5. Name of party alleged to be liable for damages.

Senator Leap writes:

"I would suggest that this form be made uniform and that it be placed on a piece of bristol board 9 x 4 in order that it can be enclosed in a large envelope.

"I would suggest that, when the lien notice is filed, a self-addressed post-card be enclosed in order that the County Clerk may designate the time of filing; and immediately upon the receipt by the physician of the post-card, that the physician send a copy of the lien notice to the injured person and to the person alleged to be the person injured, and also one to the person alleged to be liable for damages, marking on both of these cards the date of the filing of the notice in the County Clerk's office.

"Notice to the injured person and to the person alleged to be liable is to be sent by registered mail."

The following form of *discharge of lien* is suggested:

To the County Clerk of the County of ———

This is to certify that the Physician's lien, as filed by the undersigned, has been duly paid or released, and you are hereby authorized to discharge the said lien.

The following form of *Certificate of Cancellation* is also suggested by Senator Leap:

STATE OF NEW JERSEY }
COUNTY OF ——— } ss.

Be it remembered, That on this ——— day of ———, in the year of our Lord one thousand nine hundred and thirty-five, before me, ———, personally appeared ———, who I am satisfied is the person named in the foregoing certificate of discharge, and I having made known to ——— the contents thereof ——— acknowledged that ——— signed, sealed and delivered the same as ——— voluntary act and deed. All of which is hereby certified.

(This form is to be acknowledged before a Notary Public or Attorney.)

MATERNAL WELFARE IN BERGEN COUNTY

Reported at the request of the State Committee on Maternal Mortality, A. W. Bingham, M.D., Chairman.

The Maternal Welfare Commission was organized in Bergen County in 1932, the members being Drs. Wilson, Hallett, Richardson, D'Agostin, Knox, and Cochrane. The purpose of the organization was to promote better obstetrics. Dr. Wilson was elected Chairman, and committees were appointed to investigate and recommend procedures as to mortality statistics, similarity in hospital charts and records, and the promotion of better obstetrics by (1) lectures and post-graduate courses; (2) supervision of deliveries particularly complicated and operative; (3) investigation of maternal deaths.

These committees proceeded to carry out their work, the statistics committee meeting

with difficulty due to inability to obtain from the State Board of Health any information regarding maternal deaths. The chart and record committee completed a hospital chart which was accepted and is to be used by all the hospitals.

During the next two years these problems will be amplified in more detail and their perfection and imperfections noted in order to have a more up-to-date method of doing better obstetrics.

The Bergen County Medical Society has appointed this Committee to be permanent. Last year two more members were added, Dr. Reinhold, and Dr. Burnham who is chairman this year. The committee is functioning along four lines:

1. By holding post-graduate symposiums on different phases of obstetrics.

2. (*a*) Each hospital has its obstetrical meeting of the attending staff, at which papers are read. Interesting and abnormal cases, their diagnosis and treatment.

(*b*) The Bergen County Society has Post-graduate courses both (1) by local men (2) Rutgers University.

3. By supervision of complicated and abnormal cases in hospitals, as follows:

(*a*) All the hospitals in Bergen County require one of the attending staff to pass on any Caesarian Section.

(*b*) One or two hospitals require consultation by a member of the obstetrical staff for any abnormal case except low forceps and normal deliveries.

4. By the investigation of maternal deaths.

On this committee there has been appointed one man to investigate each death as reported. Each year this report is given.

We in Bergen County are heartily in favor of this commission and feel that a great deal more can and will be done in the cause of better obstetrics.

L. Burnham, M.D., *Chairman,*
Maternal Welfare Commission.

THE RADIOLOGICAL SOCIETY OF NEW JERSEY

Dr P. S. Avery, New Brunswick, Secretary of the *Radiological Society of New Jersey,* has sent the following communication:

The Antituberculosis League of New Jersey has recommended that all school children receive the Mantoux test for the purpose of detecting early tuberculosis; and it has been estimated that not more than 50 per cent of all children tested would require further clinical study and x-ray examination. This would entail the examination of many thousands of school children in this state by x-ray.

For the purpose of discussing this problem a special meeting of the *Radiological Society of New Jersey* was called on December 15, 1934, and the following resolutions were made and approved:

Be it resolved:

I. Examination to rule out or prove the presence of a tuberculous lung condition should be an individual one, made in the most scientific manner, by competent Roentgenologists as well as competent clinicians. It should not be conducted by the mass production method.

II. A negative x-ray examination may be followed in three months by a positive one. These surveys therefore have a questionable value unless repeated at frequent intervals, in that they create a sense of false security in the mind of the parent or guardian, and occasionally a loss of valuable time while the disease remains unrecognized and unsuspected.

III. We recommend that after a positive Mantoux test, and a proper clinical examination and history taking, arrangements should be made in local districts to have the children examined according to the facilities available, the fees charged to be based upon the social status of the child, and borne by the parents.

IV. The Radiological Society of New Jersey does not approve of the use of photographic paper in the examination of the lungs for the following reasons:

First: The diagnostic detail is inadequate, and photometer tests definitely prove that the paper is 60 per cent less efficient than the celluloid film.

Second: Examination by paper and a later examination by the film method for the comparative study of the progress of a tuberculous process has no practical value, because of the difference in the detail and contrast between paper and film.

Third: Accurate diagnosis of a tuberculous lesion on photographic x-ray paper is impossible.

Fourth: To our knowledge there are no tuberculous sanataria or hospitals that have adopted the use of x-ray photographic paper for the routine examinations of the lungs. The cheapness of the paper does not compensate for an erroneous interpretation.

NEW JERSEY NEURO-PSYCHIATRIC SOCIETY

May I take this occasion to inform you of the recent organization of the *New Jersey Neuro-Psychiatric Association?* For many years there has been a growing demand on the part of the neuropsychiatrists of the state to have an organization of this type. In February of this year, Dr. C. C. Beling issued an invitation to the neuropsychiatrists of New Jersey to attend a meeting at the Academy of Medicine of Northern New Jersey for the purpose of organizing this society. Forty-six men representing widespread counties attended this meeting and committees were appointed to draw up a constitution and by-laws. At a second meeting on March 13, 1935, a constitution was adopted and the following officers were elected.

Dr. C. C. Beling, President,
Dr. Marcus Curry, Vice-President,
Dr. Lewis H. Loeser, Secretary,
Dr. Henry A. Davidson, Assistant Secretary,
Dr. Guy Payne, Treasurer.

Article I. of the constitution of this Association states that "the purposes of this organization shall be to promote the science and practice of neuropsychiatry, and to maintain high professional standards in that field."

Physicians who have been graduated from reputable medical schools and whose practices are devoted largely or exclusively to neurology or psychiatry shall be eligible for membership in this organization.

May we suggest that the *State Medical Society* take official recognition of the formation of this body, and that in matters of interest to neuropsychiatrists, *this group be consulted and advised?* You will find the neuropsychiatrist of this state eager and willing to coöperate on all matters of policy of mutual interest.

LEWIS H. LOESER, M.D., *Secretary.*

THE MEDICAL VETERANS OF THE WORLD WAR

The Medical Veterans of the World War, an organization founded by Col. Victor C. Vaughan, to maintain an organization amongst those doctors in government service during World War. The organization is still active and holds a dinner meeting at the time and place of the A. M. A. meeting, with a usual attendance of about 250 doctors from all over the United States,—and this year from Canada also.

Its next meeting will be held in Atlantic City on the evening of Wednesday, June 12, 1935, at 7 p. m. at Kornblau's Restaurant on the Boardwalk at Virginia Avenue. The program will include high officers of the U. S. Army, Navy and Public Health Service, and a distinguished diplomat as speaker. The affair will be informal.

New Jersey had about 500 doctors in the World War, and a goodly number of them should attend this dinner. The cost will be $2.50 and tickets may be bought at the General Information Desk of the A. M. A. convention.

The local committee of arrangements at Atlantic City is headed by Dr. David B. Allman.

ALBERT GROVES HULETT, M.D.,
East Orange, N. J.
President, Medical Veterans of
World War of U. S.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS

DIPHTHERIA TOXOID

County	To Mar. 31	Average per Month	Month of April	Total to April 30
Atlantic	161	17.8	26	187
Bergen	1791	199.	191	1982
Burlington	24	2.6	48	72
Camden	250	27.7	31	281
Cape May	35	3.8	50	85
Cumberland	62	6.8	3	65
Essex	1729	192.1	344	2073
Gloucester	339	37.6	268	607
Hudson	193	21.4	56	249
Hunterdon	81	9.	4	85
Mercer	24	2.6	11	35
Middlesex	798	88.6	41	839
Monmouth	368	40.8	144	512
Morris	237	26.3	401	638
Ocean	38	4.2	5	43
Passaic	869	96.5	1444	2313
Salem	47	5.2	30	77
Somerset	785	87.2	15	800
Sussex	378	42.	25	403
Union	293	32.5	180	473
Warren	40	4.4	16	56
Totals	8542	949.1	3333	11875

SMALLPOX VACCINE

County	To Mar. 31	Average per Month	Month of April	Total to April 30
Atlantic	126	14.	3	129
Bergen	550	61.1	52	602
Burlington	53	5.8	34	87
Camden	218	24.2	5	223
Cape May	442	49.1	3	445
Cumberland	29	3.2	3	32
Essex	1008	112.	164	1172
Gloucester	264	29.3	14	278
Hudson	0	0.	10	10
Hunterdon	68	7.5	0	68
Mercer	22	2.4	2	24
Middlesex	615	68.3	9	624
Monmouth	25	2.7	11	36
Morris	335	37.2	85	420
Ocean	16	1.7	26	42
Passaic	833	92.5	280	1113
Salem	27	3.	65	92
Somerset	224	24.8	20	244
Sussex	10	1.1	20	30
Union	110	12.2	134	244
Warren	95	10.5	0	95
Totals	5070	563.3	940	6010

EXPENSE ACCOUNTS

To All Officers and Committees:

It is requested that all bills and statements of expense for account of the closing fiscal year be sent to the Chairman of the Finance Committee, Dr. H. R. North, before May 20th, so that the books may be balanced at the end of the month. No checks will be sent out after the 25th. Bills on account of the recent Annual Meeting should *not* be included, as they cannot be paid till after June 1st.

E. J. Marsh, *Treasurer.*

OBITUARIES

HENRY B. COSTILL, M.D.

Dr. Henry B. Costill, a prominent physician of Trenton, died in his home on April 27, 1935, aged 75 years. He was a native of Trenton and graduated from the Medical School of the University of Pennsylvania in 1882 and has spent the greater part of his professional life in Trenton, practicing as a surgeon.

Dr. Costill took a prominent part in civic affairs and served for thre years as Director of the Department of Health of New Jersey. He also served on the New Jersey Board of Medical Examiners. He was chief physician of the Medical Advisory Boards of New Jersey during the World War.

Dr. Costill was active in medical societies both local and state. He served as President of The Medical Society of New Jersey in 1921-1922, and was held in high respect by his colleagues.

The following resolution was passed by the Board of Trustees of The Medical Society of New Jersey on April 29, 1935:

"The death of Dr. Henry B. Costill, a Past President of this Society has just been announced, and it is most appropriate that this Society be at this time reminded of the great service that he rendered.

"In 1922 the medical profession had so little political influence that a law was passed licensing chiropractors and creating a separate board for them, the legislators even refusing to give the physicians a hearing. As a result of this treatment the Society got busy and organized the first Welfare Committee, which in one year secured the repeal of this act and the passage of the limited practice act which is now in force. In its passage through the legislature, Dr. Costill showed rare political acumen, and outstanding ability in dealing with men. Those of us who were members of the Welfare Committee at that time realize, and we want the Society to know, that he was the guiding spirit of the technic in the passage of the law through the legislature, as he was in all other questions that had any bearing on public health."

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING MARCH, 1935

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
John G. Wilson	83	Mch. 9, 1935	280 High St., Perth Amboy	Same	Myocarditis. Pulmonary edema. Arterio sclerosis.
Benj. M. Fletcher	29	Mch. 18, 1935	Orange Memorial Hospital, Orange	9 Pomonia Ave., Newark	Fall from horse, accidental.
George I. McKelway	84	Mch. 8, 1935	543 Hillcrest Ave., Westfield	Same	Carcinoma of bladder.
Harris R. Simmons	84	Mch. 2, 1935	557 Bramhall Ave., Jersey City	Same	Coronary arterio sclerosis. Angina pectoris.
Levi B. Hirst	74	Mch. 6, 1935	634 Federal St., Camden	Same	Cerebral hemorrhage.
Albert B. Nash	80	Mch. 10, 1935	10 S. 13th St., Newark	Same	Ac. suppurative cholecystitis. Chr. nephritis. Arterio sclerosis.
James H. Trainor	53	Mch. 29, 1935	30 Burr Road, Maplewood	Same	Chronic myocarditis.
Henry W. Kice	74	Mch. 6, 1935	State Hospital Greystone Park	22 Princeton Ave., Dover	General arterio sclerosis. Chr. myocardial degeneration. Chr. nephritis.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MAY				JUNE			
2	Hudson	9	Passaic	11	Bergen	19	Middlesex
7	Camden	10	Atlantic	12	Mercer	20	Morris
7	Cape May	14	Bergen	13	Somerset	26	Monmouth
8	Mercer	14	Sussex	13	Burlington		
8	Ocean	15	Middlesex		JULY		
8	Burlington	16	Gloucester	9	Cumberland	23	Hunterdon
9	Essex	22	Monmouth	16	Warren		

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Hotel Traymore April 21st, 1935, at 8:30 p. m., with Dr. C. C. Charlton presiding as President and seventy members and guests present.

TRAFFIC REGULATIONS

Dr. Charlton introduced Sergeant Barab of the Traffic Department, who requested the physicians not to take advantage of their privileges, but to try to observe the traffic and parking regulations more carefully than they have in the past.

HOSPITALIZATION AND E. R. A.

Dr. S. T. Snedecor, Second Vice-President of the State Society, spoke briefly of the attitude hospitals have been taking with regard to the physician in that the hospitals are now getting many patients that should go to their doctors; and if hospitalization is necessary, the doctor will send them there. He stated also that 85 per cent of the patients are treated free by hospitals, leaving only 15 per cent who pay.

EIGHT-HOUR SERVICE FOR NURSES

A letter from the Secretary of the Nurses Alumnae Society was read requesting the opinion of the physicians of Atlantic City regarding the eight-hour plan for nurses. Dr. Charlton appointed a committee, Dr. D. W. Scanlon, Chairman, and Drs. D. B. Allman and J. H. Mason, to investigate the plan and report at the coming meeting.

NEW MEMBERS

Dr. H. S. Davidson, reporting for the Board of Censors, recommended Dr. W. E. Eckert and Dr. Peter H. Marvel for membership and Dr. N. J. Whitehill for Associate Membership. They were elected.

The application of Dr. Hayfield, who has only been in practice for six months, was held under advisement until he has been practicing longer.

BROADCASTING

Dr. H. S. Read, reporting for the Broadcasting Committee, stated that the radio fund was exhausted and would have to be replenished before furthers ads could be put in the local papers.

PUBLIC HEALTH HOUR

Dr. E. H. Harvey spoke of the Public Health Hour and had cards for those participating to place in their offices to let their patients know what hour they were setting aside for this work.

LEGISLATION

Dr. D. B. Allman for the Legislation Committee spoke of the osteopaths' and chiropodists' bills coming up; and a protest was signed by the members of the Society to be sent to our legislators regarding these bills.

LIEN LAW

He also explained the points of the new Lien Law which has been put into operation. This new bill supersedes the one under which some two or three counties have been working. Dr. Allman stressed the importance of every member being familiar with the ruling under this new law, and the necessity for physicians working together under it where the wards are not extensive. He also brought out the fact that insurance company adjusters were going to be on the alert for any slip-ups in the filing of these claims.

RELATIONS TO OTHER SOCIETIES

There will be a meeting of the American Therapeutic Society on June 7th and 8th at the Hotel Traymore. This Society will meet with it on the evening of June 7th.

There will be a meeting of the New Jersey State Dental Association at the Ambassador Hotel April 24, 25 and 26 to which all members of this Society are invited.

The New Jersey State Medical Society meeting will be held at Haddon Hall on April 30th and May 1st and 2nd.

The May meeting of this Society will be a business meeting.

It was voted by the members that flowers should be sent to Dr. J. S. Irvin, Secretary, who is ill at his home.

Dr. C. L. Andrews urged the members to attend the basketball games at the Convention Hall on April 13th.

SCIENTIFIC PROGRAM

The Scientific Program was presented as a symposium on practical suggestions for the management of certain ear, nose and throat conditions:

John R. Page, M.D., Surgeon Director of the Ear Department, Manhattan Eye, Ear, and Throat Hospital, New York, discussed the management of ear diseases;

George Coates, M.D., Professor of Otolaryngology, University of Pennsylvania, spoke upon diseases of the nose; and

Ross Faulkner. M.D., Surgeon Director, Throat Department, Manhattan Eye, Ear, and Throat Hospital, discussed various conditions occurring in the throat.

Dr. Page, whose paper in full accompanies this report, emphasized the importance of early paracentesis of the drum in acute conditions, as tending to decrease the incidence of mastoiditis; and advocated reasonable delay in the performance of mastoid operations. He also stressed the importance of determining the exact nature of ear infections by bacteriological examinations.

Dr. Coates outlined the function of the nose in connection with respiration, and the important relation to disease of any disturbance of its drainage. He brought out very clearly the function of the nose as a barrier against infection and how, because of its structure and the nervous mechanisms regulating its functions, congestion, infection, and disease might follow even minor functional and structural abnormalities.

The corrective surgery of the nose, and especially meddlesome surgery, was discussed at some length, bringing out many points of practical importance and utility.

Dr. Coates deplored the ill-advised use by the patients of all sorts of nasal antiseptics and especially the common use of ephedrine.

Dr. Faulkner also disapproved of the indiscriminate use of solutions of all kinds in the throat, and condemned the electrocoagulation of tonsils as not only painful and tedious, but possessed of many dangerous potentialities. He emphasized the numerous causes of hoarseness and its importance, when persistent, as a symptom indicating the necessity for careful search for the cause.

He discussed mostly the acute conditions in the throat and the importance of bacteriological examinations to determine exactly the nature of the infection, emphasizing the fallacies of diagnosis by inspection alone. In the acute stages Dr. Faulkner disapproved of anything stronger than water or saline solution as local irrigating agents. Relief of pain was important but the too frequent or too vigorous use of irritating local applications should be discouraged, especially in the first 24-48 hours. He preferred hot steam inhalations or inhalations of benzoin or camphor vapors. He called attention to the relation of postnasal discharge to chronic laryngitis. Difficulty in swallowing always suggests the possibility of retropharyngeal abscess.

In the discussion of these papers, Dr. E. H. Harvey commented on the tonsils as a bugbear to the practitioner and on the difficulty of evaluating for parents different methods of tonsillectomy. Dr. E. H. Nickman commented on the treatment of early middle-ear infections in children and Dr. S. L. Salasin again emphasized the importance of bacteriological diagnosis of diphtheria. Dr. S. Barbash spoke of alkalinization in upper respiratory tract infections, and Dr. W. E. Darnall agreed with the speaker on the irritating action of Zonite and similar preparations on the nasal mucosa, and also discussed the relation of intestinal toxemia to sore throats.

Dr. Charlton again emphasized the importance of early middle-ear drainage as lessening the incidence of mastoid infections and emphasized that the big tonsil was often not as dangerous as the small embedded tonsil that appeared innocent at first glance.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on Tuesday, April 9th, the President, Dr. David Corn, presiding.

Drs. David Corn and Samuel Alexander had explained the new system of follow-up of tuberculosis cases as approved by the Executive Committee and printed in the April Bulletin.

GRATUITOUS SERVICES

Dr. Victor A. Blenkle, Chairman of the Public Health Committee, read the proposed policy of the Bergen County Medical Society in regard to the gratuitous services requested of members of the medical profession, as follows:

"It is the aim and wish of the Bergen County Medical Society that all pre-school children have the privilege of being examined regularly by the family doctor and of having the defects corrected. It is recognized by the medical profession that this work is done far better by the family physician; and it is hereby recommended that the pre-school children be examined and taken care of by him.

"Frequently physicians, especially school physicians, are asked to do this work gratuitously.

"It is the consensus of the members of the Bergen County Medical Society that physicians, whether they are employed as school, board of health, or child hygiene clinic physicians, shall not do pre-school examinations unless they receive a special remuneration for such services. Furthermore, that no pre-school children be examined just prior to entering school for the first time unless one parent or guardian be present to be made personally aware of the defects found.

"It is a right and duty of the medical profession to determine for itself what individuals, institutions, and organizations have a claim upon physicians for gratuitous services. Therefore, let the examining private physician decide who is deserving of gratuitous service."

This report had been approved by the Executive Committee on March 26th. Dr. L. W. Black moved that the Bergen County Medical Society approve the policy. Dr. S. Alexander seconded the motion, which was passed unanimously.

NEW MEMBERS

The following were elected to membership:

Junior: Dr. Addino Bernardien, Bergen Pines.

Associate: Dr. H. A. Hendrickson, Edgewater.

The following application for membership was read:

Junior: Dr. Rubin Grossman, Garfield.

The following junior members are to come up for regular membership in May:

Dr. Joseph M. Coppoletta,

Dr. Hyman Oren.

COMMUNICATIONS

The following communications were mentioned by the Secretary:

1. A letter from Dr. Leo Haggerty in regard to the Osteopathic Bill before the Assembly.

2. A letter from Dr. L. W. Wilkes notifying us that the Physicians' Lien Law and the Professional Board's Law had been signed by Governor Hoffman.

3. A letter from Dr. Lancelot Ely, President of the Medical Society of New Jersey, requesting a copy of our Constitution and By-Laws for the purpose of standardizing the membership lists in various Counties.

4. A letter from Mr. George C. Shicks, Secretary of the Joint Committee of Pharmacists and Physicians, for the adoption of the New Jersey Formulary.

The letter announced an open meeting at the Newark Academy of Medicine at 8 p. m. on April 15th.

THE PUBLIC HEALTH HOUR

Dr. Victor A. Blenkle, Chairman of the Public Health Committee, presented the new Public Health Hour cards or posters of The Medical Society of New Jersey to be placed in the doctors' offices together with cards and letter forms urging parents to bring children to the doctor for immunization.

Mr. C. R. Newell, District Health Officer, spoke on the Public Health Hour and presented the following statistics:

Diphtheria toxoid taken out, 2985 doses; reported used, 1791.

Smallpox vaccine taken out, 1085; vaccine used, 550.

Only 657 of the 1791 diphtheria immunizations were on pre-school children, 1154 were on school children. Approximately 1200 children had been immunized in school clinics and Baby-Keep-Well stations, and some 500 in doctors' offices.

One hundred cases of diphtheria have been reported in Bergen County since the Public Health Plan went into effect.

In 1934 there were 13 deaths out of 104 cases of diphtheria.

FINANCES

The Treasurer, Dr. L. A. Markley, announced that $2899 have been forwarded to the Treasurer of The Medical Society of New Jersey, and that there was a cash balance of only $858. He stated that the County Society has been spending an average of over $400 during the past two months.

SCIENTIFIC

Dr. David Goldberg, Chairman of the Scientific Committee, turned the meeting over to Dr. H. B. Wilson who introduced Dr. John R. Finley, Associate in Obstetrics and Gynecology of the Sloane Hospital, New York City, and Dr. A. W. Bingham, President of Staff and the Director of the Obstetrical Service of the Orange Memorial Hospital.

Dr. Finley spoke upon the successful use of pessaries in about 25 per cent of the women who had retro-displacement of the uterus following childbirth.

Dr. Bingham discussed the various important procedures of prenatal care. He particularly stressed his opinion that overweight in pregnancy was more apt to lead to trouble and he suggested that more emphasis be placed on diet and exercise.

The discussion was continued by Drs. Frederic Quigley, of Hudson County; G. Finke, D. Corn, L. Burnham and H. B. Wilson.

Dr. Christian P. Segard, of the Wisconsin Alumni Research Foundation, gave a very interesting talk on "Irradiated Vitamin D Milk".

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held April 2, 1935, at 9 p. m. in the Cooper Hospital, Camden, N. J. The Society was the guest of the Cooper Hospital Staff. Dr. F. William Shafer, President, presided.

It was moved by Dr. A. H. Lippincott and seconded, that the Society endorse at this regular meeting the resolutions adopted at its special meeting of March 8, 1935, relative to the death of a member, Levi B. Hirst.

REPORTS OF COMMITTEES

Dr. D. F. Beatley, Chairman of the Post-Graduate Committee, reported that he had received over forty acceptances for the Post-Graduate Course of Lectures (70 acceptances by April 8, 1935).

Dr. E. G. Hummel, Chairman of Public Health Committee, requested that his committee be prepared to report at the next meeting. This was placed in the form of a motion and passed by the Society.

MEDICAL EXAMINER

Dr. T. K. Lewis, Chairman of the Public Relations Committee, presented the report of this committee, which had been authorized to act on the question of medical examiner for Camden County. The following report and recommendations were read:

"It is the opinion of your committee that the present custom of electing coroners from among the laity is fundamentally wrong and illogical. That anyone not regularly licensed to practice medicine should be given the authority to sign death certificates, particularly in problematical cases, is a state of affairs directly in violation of every principle of common sense, logic and justice. When even the regularly trained physician is often inadequately equipped to ascertain the cause of death,

it seems doubly absurd that any untrained member of the laity should be granted, legally, the right to establish the cause of death in such problematical cases as fall under the jurisdiction of the coroner.

"Unquestionably the office of Medical Examiner and such a department as was described to us at the last meeting of this Society cover all the demands of adequacy and represent an ideal set-up. However, at the present time, with practically all of our municipalities faced with financial shortage and seeking additional means of cutting down budgets, it would seem unwise to press the matter. In addition, it is a question whether the City of Camden with a population of about a hundred thousand odd is large enough to maintain such a department. Regardless of the size of the community, certain fundamental requirements would be essential. Laboratory facilities would be necessary. In addition to the medical examiner other trained personnel would be indispensable, such as toxicologist, chemist, orderlies, etc. Should such a department be established, for economy's sake, it would seem wise to plan it on a county-wide scale. Better still the inclusion of our two sister counties might be considered.

The following lines of activity are suggested for your consideration:

"1. Approach of the adjacent County Medical Societies, with the object of selling them the idea of a group plan for economic maintenance of a medical examiner's center.

"2. A request by our County Medical Society that the State Legislative Committee prepare the legislation necessary to make possible the creation of such a department either for cities the size of Camden or for county groups.

"3. For the immediate future, that the Camden County Medical Society communicate with the leaders of the various parties and express the desire of the Society that in the future all candidates for the position of coroner shall be licensed doctors of medicine.

"Respectfully submitted,

"(signed) T. K. Lewis, Chairman.
"Public Relations Committee."

Upon motion from the floor the society moved and passed that the recommendations embodied in this resolution be adopted by the society.

SCIENTIFIC PROGRAM

The Scientific Program consisted in the presentation of eight cases by members of the Staff of the Cooper Hospital:

1. Eclampsia with Massive Cerebral Hemorrhage—Autopsy. A. B. Davis, M.D.
2. Transurethral Resection, A. H. Lippincott, M.D.
3. Evulsion of the Scalp, A. S. Ross, M.D.
4. Adeno-carcinoma of Ovary, T. B. Lee, M.D.
5. Atypical Blood Dyscrasia, T. M. Kain, M.D.
6. Multiple Abscess of Lung—Autopsy, E. G. Hummel, M.D.
7. Pylorie Obstruction as a Sequel to Peptic Ulcer, R. L. Sharp, M.D.; P. M. Meeray, M.D.
8. Frontal Sinusitis with Epidural Abscess Followed by Osteomyelitis of Long Bones, O. R. Kline, B. F. Buzby, M.D.

The Secretary announced the enactment of a new Physicians' Lien Law and its signature by the Governor. He also announced the meeting of April 3, 1935, at 6 p. m. of the Fourth Councilor District.

The Business Committee met following the meeting and discussed with the Treasurer the members who are delinquent in their dues to the society. The Treasurer was instructed to notify these members of their delinquency and the necessity for immediate payment to maintain their membership and the privileges accorded the members of this society.

The meeting was then adjourned. There were ninety-five members and guests present. A collation was served under the direction of Miss Helen Markley, Chief Dietitian of the hospital.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

April's unusually inclement weather did not prevent a good attendance at the quarterly meeting of the *Cumberland County Medical Society* held Tuesday afternoon. Dr. S. T. Bennett, President, presided.

HOBBY EXHIBIT

The hobby exhibit at the State Medical Society meeting, April 30, at Atlantic City, was discussed and all members were urged to make a contribution of any hobby they may be cultivating.

LIEN LAW

The physicians' lien law, enabling doctors to obtain 20 per cent of the award in accident suits, has passed the State Legislature, and members stated it seems an equitable adjustment of the part the doctor has in caring for the injured.

MATERNAL WELFARE

Dr. Mary Bacon discussed the progress of the maternal welfare work, and stated Cumberland County has the lowest mortality of any county in the State, not one death occurring in February.

DIPHTHERIA PREVENTION

The diphtheria immunizing campaign was discussed and plans formulated to make the campaign coincident with National Health Week, beginning May 1.

NEW MEMBERS

Dr. Muse A. Sheppard of Elmer, was elected a member and Drs. M. R. Faulkner, B. Bardfield, and Benjamin Berkowitz were proposed for membership.

E. R. A.

Dr. Leslie E. Myatt discussed "Our Relationship with the E. R. A." He spoke of the coöperation of the directors, especially in Bridgeton and Millville. The extent of the work and its changeability made many difficult problems, but patience and an attempt at mutual understanding has ironed out most of the difficulties.

SCIENTIFIC PROGRAM

Judge LeRoy W. Loder was the guest speaker for the meeting. He expressed his interest in the discussion of the workings of the E. R. A. as affecting the doctors and emphasized the necessity of medical care and supervision as essential to the public good, and that this care should mean its proper remuneration. He spoke of the great benefits coming from the workmen's compensation laws, and as compared with former conditions thousands are helped while sick, and returned to occupational usefulness.

The apparent contradiction in testimony of doctors on the witness stand is largely due to the hypothetical questions given by the lawyers. The same questions reduced to a simple language would produce the same answer. Legal questions should be determined by the lawyer and the medical ones by the doctors.

Dr. M. F. Sewall spoke on "The Cost of Efficient Medical Care". The commissions of the large charitable foundations reported in favor of group practice in community centers with health insurance.

"These plans start with economy measures and soon pass from the doctors to the politicians", said the speaker.

"We, as doctors, are willing to subscribe to any change benefiting and protecting the public. Standards are bound to fall in mass production. Personal contact with the patient regulates practice better than any other method."

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine, Newark, Thursday evening, April 11, 1935.

SCIENTIFIC SESSION

The Scientific Program was arranged by the Committee on Cancer. Dr. Charles F. Geschickter of the Johns Hopkins Hospital, Baltimore, spoke on the subject of "Benign Tumors of the Breast and their Endocrine Relationship", and Dr. Murray M. Copeland of the Union Memorial Hospital, Baltimore, spoke on the subject "Cancer of the Breast in Relation to Diagnosis and Treatment". During the scientific portion of the meeting the Chairman of the Cancer Committee, Dr. H. B. Orton, presided.

BUSINESS SESSION

President John F. Condon then conducted the business session. It was announced that the Women's Auxiliary had donated Five Hundred Dollars to the Physicians' Emergency Fund. This generous act was acknowledged by a grateful and appreciative vote of thanks.

The following new members were elected:—

Regular

Roscoe W. H. Buckner, Newark
Angelo M. Carlucci, Newark
Paul M. Champlin, Irvington
Philip U. Fava, Newark
Arthur A. Giffoniello, Newark
Lester M. Goldman, Newark
E. J. Kaderabek, E. Orange

Associate

John H. Alcamo, Newark
William J. Bernhard, E. Orange
Louis Danzis, Irvington
Harry H. Kleinberger, Millburn
Lucille F. Miller, Orange
Charles I. Nadel, Bayonne

After the regular society meeting adjourned, the Essex County Delegates to the Annual Meeting of the Medical Society of New Jersey organized.

GLOUCESTER COUNTY

H. B. Diverty, M.D., Reporter

An interesting program featured the annual meeting of the *Fifth Councilor District* of the State Medical Society held on the afternoon of April 18, at the Woodbury Country Club. The *Gloucester County Medical Society* was host to visiting physicians. Ninety physicians were present.

Among the prominent guests were Dr. Lancelot Ely, of Somerville, President of the State Society; Dr. E. R. Mulford, Burlington County, and Dr. Frederic J. Quigley, of Hudson County, ex-Presidents; Dr. Frank Overton, Editor of the State Medical Journal; Dr. LeRoy A. Wilkes, Executive Secretary, and Dr. J. B. Morrison, of Newark, Secretary of the State Society.

The program opened with introductory remarks by Dr. Aldrich C. Crowe, of Ocean City, Councilor of the Fifth District, which includes Cape May, Atlantic, Cumberland, Salem and Gloucester Counties.

Dr. Crowe introduced Dr. E. I. Ulmer, of Gibbstown, who presided at the scientific session.

Dr. Hilton S. Read, of Atlantic City, spoke on the subject "This Medical Mess,—Why?" He quoted misleading advertisements and press notices and referred to a long series of wall exhibits collected by the Atlantic County Medical Society. He described the radio broadcasting plan of the Atlantic County Society, and urged that the medical societies adopt an agressive policy in place of one of obstruction, or even passive acquiescence.

Dr. E. J. G. Beardsley, of the Jefferson Hospital, Philadelphia, Pa., gave an address that was both educational and inspirational on the subject "The Opportunities and Responsibilities in the Every-Day Practice of Medicine". He dwelt on the basic principle that every man is the product of his ancestry, and that every patient has a personality which requires treatment as scientific as that of his physical ailment. He also extolled the family doctor as the ideal practitioner, for he treats the entire patient, while the specialist treats only a part.

At 5:30 o'clock a dinner was served under the direction of a committee consisting of Dr. Chester I. Ulmer, of Gibbstown; Dr. W. J. Burkett and Dr. Herman W. Wright.

After the District meeting, a meeting of the *Gloucester County Medical Society* was held, at which reutine business was transacted.

HUDSON COUNTY

By John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, April 2, 1935, at the Carteret Club. The meeting was called to order by the President, Dr. Chapman, at 9:25 p. m.

SCIENTIFIC PROGRAM

Dr. Chapman introduced Dr. Arthur M. Wright, Professor of Surgery at New York University, Bellevue Hospital Medical College, whose paper was "Intestinal Obstruction".

Discussors: Drs. T. J. Schuck, M. A. Swiney, William N. Barbarito, Frank Pearlstein, L. W. Dodson, H. J. Perlberg, A. P. Rieman and Wright.

Dr. Chapman thanked Dr. Wright for his valuable time and for his coming here tonight. Dr. Chapman asked Dr. Wright to remain with us throughout our business session.

LIBRARY

The President introduced the subject of library, and said: "I requested the Executive Committee to go on record, for or against, bringing before the Society the question of a Library and the appointment of a Librarian for a period of five years; and further, that this Society appropriate $100.00 a year for the purpose of buying medical journals and medical periodicals to be used in the library. The purpose of this library is to gather from the estates of deceased members of this Society any medical books or medical journals of interest to the Society. I would like a discussion upon this subject tonight."

Dr. N. Alter: "I think Dr. Chapman's proposition is not only excellent but very timely. We have to get started on independent medical progress. With all due respect for the outside speakers who at times brings us valuable information, it has to be remembered that higher education is active and not passive. We have to educate ourselves for independent work of our own material and we have to develop independent ability of judgment.

For this kind of work a reference library is indispensable. It is a fallacy to depend entirely on information and we cannot depend upon the New York libraries only. Therefore, it is absolutely necessary to have a good reference library. It is not a question of establishing a large library at once, but let's start one with the thought of the future."

Dr. L. A. Pyle: "There is room in the main branch of the Public Library, situated at Jersey Avenue and Montgomery Street, which is called a Medical Library. This Library contains all of Dr. Gordon K. Dickinson's medical works. Although I feel at the present time that Dr. Dickinson's collection of books is out of date, nevertheless this room could be used as the beginning of a Medical Library in this county with very little cost to the County Society."

Dr. B. T. D. Schwarz: "Some time ago I spoke to Mr. Miller, an employee at the Public Library, and he stated the Library was willing to coöperate with the physicians of Hudson County in any way they thought fit, but up to the present time there are very few men who avail themselves the opportunity of using it."

Dr. L. A. Pyle moved that a suitable committee be appointed of three men to investigate the Medical Library, and to make an analysis of the situation and report to the Society. This motion was adopted.

AN ACADEMY OF MEDICINE

Dr. Chapman: "For a number of years there has been a discussion by various members on the establishment of an Academy of Medicine in Hudson County. It has come to my attention recently, of two or three buildings that could be bought reasonably. One building in particular the Society tried to get a few years ago for $30,000, it can now be procured at $10,000. It is very likely that this building would be free from tax. However, I bring this up for the purpose of having the Board of Trustees look at this building and report back to the Society."

Dr. M. Shapiro moved that the Board of Trustees look at these buildings and report to the Society. Motion carried.

POST-GRADUATE COMMITTEE

The Post-Graduate Committee called attention to a course of lectures on "Applied Physiology" now being held in the Amphitheatre of the Jersey City Medical Center Friday evenings.

REPORT OF PUBLICITY COMMITTEE

The Chairman, Dr. T. A. Higgins, reported that the radio broadcasts are continued three days each week, and 62 talks have already been given. The future speakers have been arranged through April and May. About two-thirds of these future speakers have volunteered their service.

Dr. Higgins: The new green cross auto insignias are here tonight and are ready for distribution. The red cross insignias may be exchanged for the new green ones without cost. You are urged to do this lest some authority in the American Red Cross may call on you to defend your legal right to use the Red Cross emblem.

The Publicity Committee has taken a great deal of time and effort to secure the privileges and courtesies which the Police Departments throughout Hudson County have agreed to extend. In spite of the fact that every concession has been granted, I find that less than ninety of our members have secured the insignias, which are necessary to enable the police to identify the doctor's car. All that is necessary for you as an individual is to purchase a pair of plates at $1.50 and then display them on your car. This particular activity only needs that much coöperation from you to make it a success.

MEDICAL ECONOMICS COMMITTEE REPORT

Dr. Pyle: "The Medical Economics Committee had a special meeting a week ago Friday, March 22nd. to which we invited Dr. E. Zeh Hawkes, who is Chairman of the E. R. A. Committee and also Chairman of the Essex County E. R. A. Committee. We questioned him on the ways and means of getting the work in Hudson County started. He answered all our questions, as a result of which the

committee decided that the President appoint his own committee and to send out a questionnaire to all practicing physicians in Hudson County with a return postal card, asking whether or not he wishes to work under this E. R. A. plan. There was one question which I feel I must explain: 'At the present time (I do) (I do not) receive financial compensation from positions held under Federal, State, County, or Municipal Government.' The reason is this: In the beginning of the E. R. A., no physician who received any salary from the Government was entitled to treat patients and receive money for it from the E. R. A., but that has been changed somewhat; they can now participate in that if their salary is under $3000 a year, a total salary, if permission is given to them upon recommendations from the County Society. The County Society has to recommend that they may work under this plan. So it is not the intent of the committee to be inquisitive, so that in case anyone wishes to do this class of work, the ball will at least be rolling. We were asked to take care of this work in this county. I don't know how long it will take; there will have to be some coöperation from the State."

Dr. Chapman: "The Medical Economics Committee refers back to the Society to empower the Chair to nominate a committee of five to act as a County Council of the E. R. A. If there is any objection to the President making these appointments, I wish you would voice them now. I will now appoint the folowing:

"J. Lawrence Evans, Chairman
"Morris Frank
"Charles A. Peterson
"A. P. Rieman
"Alfred A. Mutter.

"I also ask that you return your questionnaires as quickly as possible."

COMMUNICATIONS

Communication received from the Executive Offices of The Medical Society of New Jersey:

"I am glad to report the fact that S-134, the new Physicians' Lien Law, has been signed by the Governor and is now Chapter 146 of the Public Laws of New Jersey, 1935. This bill was signed on March 26th.

"A-28, which preserves to the Professional Boards the right to collect and expend their own funds, has been signed by the Governor and becomes Chapter 121 of the Public Laws of New Jersey, 1935. This bill was also signed on March 26th.

"Please make this announcement in your County Medical Society at its next meeting.

"(Signed) LeRoy A. Wilkes, M.D.,
"Executive Secretary."

We also received a letter from the American Medical Association, in which they emphasize "Immunize Now". National Health Week starts in May, in order to immunize all children between the ages of six months and six years.

Dr. Chapman: "The State Medical Society's convention occurs April 30 and May 1 and 2, in Haddon Hall, Atlantic City. Are there any instructions that you wish to give your Delegates at this time?"

Dr. J. L. Evans moved that the Society instruct its Delegates to bring the matter of the electric light rates before the State Society to see whether or not they are fair.

Dr. P. Maras moved that this Society instruct its delegates to bring this matter of immunizing children against diphtheria, smallpox and other contagious diseases, that the medical profession be paid for this by the State from the allotment to the State by the Federal Government or whatever way it will eventually be worked out.

This motion pertains to the private practitioners of medicine and not clinics or municipalites.

Dr. B. T. D. Schwarz seconded the motion.

MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* held a regular meeting at the Trenton Country Club, April 10th, President Cottone presiding.

Dr. Clarence B. Patten, Assistant Professor of Neurology, Jefferson College, was introduced and delivered a very interesting address on the subject "Vegetative Nervous Diseases in Relation to General Medicine". Dr. Patten evidenced a most profound acquaintance with this study of the nervous system, and impressed his audience by his distinct enunciation and entertaining manner.

A thorough understanding and acquisition of benefit from such a source can only be derived from *hearing*, rather than reading, the spoken word.

Dr. Phillips distributed literature relative to the "Public Health Hour" and again made a most earnest appeal for support of this undertaking.

Dr. Sommer presented the Court records with the attorney's bill for services rendered in behalf of the Physicians' Lien Bill, and moved that the Treasurer be authorized to pay the appended bill, the motion being duly seconded and carried.

Dr. Haggerty made a very concise report relative to Medical Legislation.

Dr. Watts again referred to the adoption of the present set-up of the E. R. A.

Dr. Vanneman urged support of the Post-Graduate Course now being conducted.

Drs. John T. Dimun and Frank P. Guidotti were regularly elected as members of the society, Drs. Cox and Moriconi acting as tellers of election.

Dr. Sommer called attention to the fact that Drs. Schildkraut and Watts were candidates for City Council, and urged the medical profession to assert its rights and support the physicians for representation.

President Cottone again appealed for a united support of present Health Welfare Measures, and called attention to the Annual State Convention to be held at Atlantic City April 30th and May 1st, 2nd.

MIDDLESEX COUNTY

Karl Rothschild, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on March 20, 1935,

at "The Pines", presided over by the President, Dr. Henry Haywood.

DIPHTHERIA IMMUNIZATION

Dr. Mann informed the society about a letter received from Dr. Lowery, County Superintendent of Schools, in which it is stated that the supervising principals do not seem to be in favor of the State Society plan for immunization of children against diphtheria. They believe that more children can be reached in the schools than in the doctors' offices. Dr. Mann believes that progress will be slow because a complete reëducation of the public will be necessary. He read a letter received from the State Society, copies of which can be mailed to parents by individual physicians. It should be the obligation of every physician practicing obstetrics to see to it that every child delivered by him is immunized in due course.

Dr. Rothschild reported on a conversation which he had with Dr. Cronk, school physician of New Brunswick. It is Dr. Cronk's belief that our efforts should be directed toward immunization of preschool children. Dr. Rowland, from his experience as physician to the New Brunswick parochial schools, thinks that people do not like to come to the doctor's office for immunization. He expects an improvement only when immunization shall be compulsory. In disagreement with this view, Dr. London believes that the matter is one of education and can be handled by the physician.

A final motion was made and seconded that the society request a supply of copies of the above-mentioned letter, to be mailed to the parents by individual doctors.

NEW MEMBERS

Ethics Committee: The credentials of Dr. Donlan, of Metuchen, were found satisfactory and on motion, Dr. Donlan was elected an associate member of the society.

LEGISLATIVE

It was announced that Dr. McKinstry will not be a candidate for reëlection to the Assembly this year. Dr. Haywood expressed the hope that another physician may be found willing to assume this responsibility.

TUBERCULOSIS SURVEY

Dr. London informed the society that a tuberculosis survey has been completed. There are sixty-three active cases in the county. There are 322 arrested cases who have not been examined by a physician in a year. All these people will be contacted and urged to see their doctors.

There are furthermore 1713 individuals under eighteen years of age in the county who have been in contact with active cases, but have never been tuberculin-tested. These tests will be performed, either through private physicians or through clinics.

SCIENTIFIC SESSION

Dr. Charles Norris, Chief Medical Examiner for the City of New York, addressed the society on the problems of the medico-legal system in the United States. We are suffering from the deficiencies of the English system, which we inherited. The Central European countries have a good system. On account of political control, we do not have such a fine organization, although we have the brains. No man with proper training is sure to obtain a position because it is being given to those with political connections. We can hardly realize the cost of these deficiencies to insurance companies and families.

Dr. Norris demonstrated comparative statistics by the use of lantern slides, and showed a film of interesting medico-legal cases.

After the customary light luncheon the meeting adjourned.

APRIL MEETING

(Minutes of Dr. Joseph F. Sandella)

The regular monthly meeting held at the "Pines" on April 17 was opened by President Haywood.

A. M. A. MEMBERSHIP

There was a letter from the American Medical Association calling attention to the difference between membership in the State Society and fellowship in the A. M. A. State Society membership is essential to a fellowship and direct application must be made to the A. M. A. The letter went to state the privileges of a fellowship.

PHYSICIANS' LIEN LAW

The new lien law was explained by Dr. Nafey. Details of the legal procedure for filing liens were given. This law is very favorable to medical interests, and we are fortunate to have it passed unencumbered by other interests. The amount of a physician's fee may not exceed 25 per cent of the total settlement in any case.

DIPHTHERIA IMMUNIZATION

Dr. Mann requested that form letters be sent to parents urging vaccination and diphtheria immunization. Dr. Cronk promised to distribute these letters to physicians in New Brunswick, and will begin publicity very soon. He also urged that the physicians coöperate to make this public service a success.

POST-GRADUATE COURSES

Dr. Rowland reported that forty-three members are taking the course of six lectures. This is a gratifying response, and the course is an excellent one. Dr. Elaine Ralli, of Bellevue Medical College, is giving a lecture on diabetes mellitus. Dr. Spiegel is devoting a lecture to cerebral injuries. Dr. Paul Klemperer, Pathologist of Mt. Sinai Hospital of New York, is giving the remaining three lectures on diseases of the liver, kidney, and vascular systems.

WOMAN'S AUXILIARY

Work on formation of a group has started. Dr. Haywood urged the support and coöperation of the members with Dr. Howley in forming this valuable organization.

LEGISLATION

Dr. J. W. McKinstry, Assemblyman from Middlesex County, entertained the meeting with an extremely illuminating talk on the duties and trials of an Assemblyman. He revealed the inner workings of the State Assembly and the intricate procedure of getting bills passed. He strongly stressed the importance to the profession of having a medical representative from the county in the Assembly, to wage the unending war against cult legislation. Dr. McKinstry capped the talk by reading a letter from an osteopathic organization urging that the Assemblymen defeat a chiropodists' bill in the Legislature. The letter was very greatly enjoyed by the society, and Dr. McKinstry said it is typical of the many letters with which Assemblymen are being deluged.

A motion was passed offering a vote of thanks and appreciation to Dr. McKinstry on behalf of the society, for his services to the medical profession while a member of the Legislature, with special reference to his fine work in passing the Lie nBill. The society further regrets that he is unable to represent us again. A motion was passed to the effect that Dr. McKinstry be drafted to again run for Assemblyman, but he declined.

Dr. McKinstry now made a motion which was passed, that the society choose one of its members to represent us in the Assembly. He stressed the importance of prompt action. He proposed Dr. Deaker, who declined. The choice of a representative is now under consideration by the society.

SCIENTIFIC SESSION

The scientific paper of the evening was presented by Dr. Lewis W. Brown, Pathologist and Allergist at the Essex County Isolation Hospital, and the Newark Ear and Eye Infirmary. The topic was "Some Varied Manifestations of Allergic Disease".

He stated that 3-7 per cent of the population suffer from allergic diseases some time during life and that there is a strong inherited predisposition to this condition. He dscussed the methods of diagnosing the allergic state. The most valuable preliminary step is the examination of secretions for the presence of eosinophiles; then skin testing and laboratory work to discover constitutional abnormalities. The skin, nose, and lungs are most frequently allergic. Any system, however, may become so. Dr. Brown used lantern slides and typical case histories to illustrate the subject. The society was deeply appreciative of this fine paper and extended its thanks to Dr. Brown.

The meeting adjourned after the usual dinner.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

EXECUTIVE COMMITTEE REPORT

A meeting of the Executive Committee of the *Monmouth County Medical Society* was held at the Fitkin Memorial Hospital Monday evening, February 11th, with the following members present: Drs. Fairbanks, President; Parry, Pregnall, Holters, Nichols, Gosling, Hunt, Rullman, Kazmann, Prout, Fisher, Herrman, Blaisdell and Featherston.

E. R. A.

A number of doctors in the county have been having some difficulty with the Emergency Relief Administration. It is felt that this is due to the lack of knowledge of the regulations set forth in the medical agreement. Therefore, a number of the members of the Executive Committee were selected to see these doctors personally and explain the routine in detail.

In the near future a meeting will be called of all the physicians in the county engaged in E. R. A. work for the purpose of reviewing the regulations. Representatives of the county E. R. A. staff will be asked to attend.

We again call your attention to the fact that only drugs listed in the National Formulary may be prescribed for E. R. A. clients.

PUBLIC HEALTH COMMITTEE

Dr. Fairbanks appointed the following men to serve on the Public Health Committee: Dr. Nichols, Chairman; Drs. Fairbanks, Quirk, Woronoff, Kazmann, Prout, Watkins and Van Oehsen.

MARCH MEETING

The March meeting of the *Monmouth County Medical Society* was held in the auditorium of the Jersey Central Power and Light Company, Allenhurst, New Jersey, on Wednesday evening, March 27, at 8:30 o'clock, and was presided over by Dr. W. H. Fairbanks, President. Approximately forty members were present.

The Executive Committee report was accepted and its recommendations approved.

HOSPITAL CASES

The Economic Committee, having presented its report to the Executive Committee, submitted the following resolutions to the society:

Whereas, The A. M. A., and Associations of Physicians in Medical Centers such as Detroit, Philadelphia and Cleveland, have asserted that hospitals run as semi-charitable institutions, receiving financial support from public funds and private donations, and professional support from physicians in private practice, giving their services without charge to ward and dspensary cases, should not be in competition with private physicians;

We, The Monmouth County Medical Society, request that all hospitals falling in the above category within this county agree to the following:

1. No patient except emergencies shall be admitted to the charitable wards of such hospital without a note signed by a licensed physician of the county.

2. Such patient's financial status shall be investigated after admittance; and if it shall be found that he is able to pay for services rendered, (a) he be transferred to semi-private accommodations, or (b) the physician in charge be allowed to send a bill, this latter especially to apply if the patient's true financial status be ascertained after discharge from the hospital.

3. No patient, after the first visit, shall be treated in the dispensary or emergency room with-

out a note from a physician, except in a case of emergency.

4. All emergency cases able to pay, shall be referred to private physicians, after rendering first aid.

5. Compensation cases shall not be treated in the dispensary except as first aid cases.

6. No services shall be rendered for pay to outside ambulatory cases that can be rendered equally well by private physicians. This shall apply to all laboratory services, such as, (a) pathology, (b) x-ray, (c) physio-therapy, (d) electro-cardiology, where it can be certified by the County Society that private physicians are equipped to give adequate service in these laboratory branches.

7. Private patients shall not be referred to free clinics for examination by specialists for convenience, or for any other reason.

8. Hospitals were originally established to give such care and treatment as physicians could not give in office or home, and their present services are to be confined to in-patients, dispensary patients, emergnecy cases, and such outside ambulatory cases as cannot be adequately treated or examined in the offices of private physicians.

The lay boards of hospitals not run for private gain should realize their responsibility in protecting the economic welfare of physicians on their staffs who render hundreds of thousands free services to hospital patients, and thus make possible the continuation of such free services.

It was moved and seconded that the resolutions be adopted and be presented to the hospitals only when 75 per cent of the members of the County Society had signified their approval of such resolutions. The motion was unanimously carried.

NEW MEMBER

Dr. C. P. Bailey, of Lakewood, New Jersey, was elected to membership, Ocean County Medical Society having signified its approval.

INSURANCE

Mr. F. Graham Biebl was allowed to present the Health and Accident Insurance Plan of The Massachusetts Protective Companies.

SCIENTIFIC PROGRAM

The Program Committee, in lieu of a scientific session, had arranged the following comprehensive program on Medical Economics:

"The Doctor and the State Medical Society", by Dr. James A. Fisher

"The Doctor's Responsibility to Public Health Activities", by Dr. Stanley Nichols

"The Doctor's Responsibility to His Profession", by Dr. William G. Herrman.

These papers concisely outlined the economic problems that are facing the medical profession today, and offered a plan whereby the solution of these problems would remain in the hands of the medical group.

HOSPITAL CONFERENCES

The following program was presented at the clinical conference of the Fitkin Memorial Hospital on Sunday morning, March 10, 1935:

"Fascial Space Infections of the Neck", Dr. James A. Fisher

"Therapy in Abdominal Tumors", Dr. L. L. Leonard

"Fever Complicating Burns", Dr. Charles D. Prout

"Lupus Erythematosa", Dr. W. F. Jamison.

The following program was presented at the Clinical Conference of the Monmouth Memorial Hospital on Wednesday evening, March 13, 1935:

"Fascial Space Infections of the Neck", Dr. James A. Fisher

"Addison's Disease", Dr. Joseph Wiener

"Hydronephrosis in a Child Due to an Aberrant Vein", Dr. Byron Blaisdell.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

Another of the series of "Clinical Club" meetings of the *Morris County Medical Society* was held the evening of Thursday, April 18, at Dover General Hospital. President McMahon called the meeting to order with about forty members and guests present.

Like its forerunners, the program was put on by the medical attaches of the hospital at which the meeting was held.

A very interesting paper on "Toxemias of Pregnancy" was presented by Dr. Edward T. Carberry. The discussion was very ably led by Dr. D. J. Geary, and participated in by a goodly number of those present, the subject being one which at present is commanding quite general and intense interest as a result of the activities of the Maternal Welfare Committee.

A paper prepared by Dr. Ervin McElroy on "Compound Fractures" was read by Dr. George L. Nicoll at the request of Dr. McElroy, who was compelled to be absent because of illness. The paper was well prepared and presented. Discussion was led by Dr. J. K. Adams, of East Orange, Attending Orthopedic Surgeon. Drawing from the knowledge of his specialty, his discussion was impressive both from the standpoint of what not to do as well as what should be done.

A very interesting presentation on the "Technic and Uses of Sacral Anesthesia" was given by Dr. Marshall D. Hogan of the staff of the State Hospital at Greystone Park, and Visiting Proctologist and Urologist of Dover General Hospital. A series of lantern slides were shown and Dr. Hogan's explanations of his subject were clearly and impressively presented. Interesting pathology of a patient presented was also shown.

After a very interesting scientific meeting refreshments were enjoyed.

OCEAN COUNTY

Abraham Goldstein, M.D., Reporter

The fourth annual meeting of the *Fourth Councilor District* was held at the Laurel-in-the-Pines, Lake Drive, Lakewood, N. J., on Wednesday, April 3, 1935, at 6 p. m.

There was a good representation of doctors when

Dr. James A. Fisher, of Asbury Park, opened the Scientific Program.

DR. MORRISON'S PAPER

Dr. J. B. Morrison, Secretary of the State Medical Society, was the first to address the gathering and told those present of the work the Medical Society is doing in the State of New Jersey, also of the increase in membership and the legislation being offered at Trenton. He also explained why it was impossible to have the dues reduced at the present time. He read for approval a paper that he is going to broadcast in Atlantic City towards the end of the month and this met with the approval of all those present.

DR. GLAZEBROOK'S PAPER

Dr. Beling was next called upon and after a few remarks, introduced the speaker of the evening, Dr. Glazebrook, who read and discussed a paper in which he told the medical profession that it is time to do something constructive, if we are to protect ourselves from political interference. If state medicine must come, we, the Medical Profession, should supervise, treat, direct and leave nothing to be done by outsiders; only by the County Medical Societies. His paper should be given thought, as it may be necessary to act upon such matters very soon. (The paper is printed on page 297.)

There was much discussion in which several members of the floor participated.

DR. MULFORD'S A. M. A. REPORT

Dr. Mulford, Past President of the State Society, rendered his report of the House of Delegates that was held in Chicago on February 15, 1935; and also requested Dr. Glazebrook to have his paper ready so that it can be taken up at the Convention of the A. M. A. at Atlantic City in June.

Dr. Adolph Towbin, Chairman of the committee that arranged the affair, read a telegram from President Ely regretting his inability to attend. The committee did wonderful work in arranging and carrying through this program and much credit is due them for its success and especially the good work of Dr. Towbin.

SOCIAL

After the scientific meeting, we all entered the dining room, which was decorated for the occasion, where a delightful meal was served and very much enjoyed by all.

Dr. James A. Fisher then made mention of the fact that we were honored to have with us tonight Dr. V. M. Disbrow, who is practicing medicine for the past fifty-five years in New Jersey. Dr. Disbrow arose among cheers of the entire audience. Dr. Disbrow is an honorary member of the Ocean and Monmouth County Medical Societies, and we believe he will soon be an honorary member of the State Medical Society. (See page 322.)

Dr. Glazebrook then answered some questions asked by those present, after which he presented us with a vocal selection of the "Flying Trapeze" and some humorous stories and poems, and was the life of the party.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Health Center, Passaic and Mill Streets, Paterson, on Thursday, April 11, 1935, Dr. Wright MacMillan, President, presiding.

E. R. A.

Dr. MacMillan introduced Mr. Louis Compton, Emergency Relief Administrator, State of New Jersey, who spoke on "New Emergency Relief Administration". Mr. Compton expressed his appreciation for the splendid coöperation the physicians were giving in carrying on the medical relief plan. He also stated that all criticism of the Relief Administration must be considered in the light of the definite limitation of funds for carrying it on. He expressed the hope that there would soon be an end to the necessity for the whole program.

Dr. E. Hawkes, District Counselor, Newark, N. J., then gave a brief outline of the historical development of the medical relief plan from its beginning in 1933.

The meeting was then thrown open for discussion. Dr. Shapiro asked why the doctors who performed surgery at the hospital on E. R. A. cases were not given some compensation. This was answered by Dr. Hawks, who said that there were insufficient funds to do this. He stated that the state has paid $750,000 to the doctors last year, and that the present plan was run by the doctors themselves.

Dr. Roemer spoke for the advisory committee, and said the difficulty met in passing on bills was whether or not the services were rendered for true emergencies. He felt, however, that now there is a much better understanding between the doctors and the Relief Administration. The discussion was then closed by Dr. MacMillan

LEGISLATION

Attention was called to pending legislation by Dr. MacMillan, and the members were advised to write their Assemblymen and Senators to vote against the osteopath and chiropodist bills now pending. (See page 323.)

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular meeting of the *Salem County Medical Society* was held at the Salem Hospital on April 10, 1935, with a good percentage of members present. Dr. Frank C. Perry, President, presided.

NEW MEMBER

During the course of unfinished business Dr. John Zappala, of Pennsgrove, having been duly approved, was elected to membership.

ANNUAL SHAD DINNER

A motion was unanimously passed to repeat the annual shad dinner at the Salem Country Club. As the shad are somewhat temperamental and run better some weeks than others, it was decided to let the shad set the date.

DATE OF MEETING

A motion was entertained to change our regular meeting night from the second Wednesday evening of the month to the second Friday. After some discussion the motion was passed.

SCIENTIFIC

Following the business session Dr. Perry announced that he had been fortunate enough to secure Dr. Teahon of Jeannes Hospital, Fox Chase, Pa., to present an illustrated lecture on cancer of the lip and mouth. Dr. Teahon gave a most comprehensive and instructive talk on this subject in which we are all greatly interested. He pointed out the fact that the most common occurrence of carcinoma about this region is on the lip, and metastasis is usually localized to the cervical glands. He also stressed the fact that the dissection of these glands is very important in attempting to effect a complete eradication of the disease and a procedure followed at his hospital very frequently. He presented several case reports that had had no recurrence after several years. The lantern slides illustrating his talk were exceptionally fine and were greatly enjoyed.

Dr. Downs, the Roentgenologist of Jeannes Hospital, accompanied Dr. Teahon and assisted in the lecture.

A free discussion followed the presentation by Dr. Teahon as to the comparative merits of surgery and radiation in treatment of malignant growths.

SOCIAL

Following the scientific meeting a lunch was served in the hospital dining room where discussion continued at a high pitch.

Our society is small,—which has its drawbacks,—but we have a grand time because everybody gets in on the discussions, and it seems more like a family party than a formal meeting. We have fun and wish more of the delegates to our society would come and join our round-table discussions.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The *Somerset County Medical Society* held its regular meeting April 11th, 1935, at the Nurses' Home of Somerset Hospital, Somerville, N. J. The meeting was called to order by President Dr. R. F. Hegeman, with twenty-one members present, as follows: Drs. Albrecht, Barbour, Cooper, Cook, Ely, Earp, Flint, Flynn, Halsted, Hird, Knight, Lawton, Lovejoy, Lukats, Pogoloff, Panigrosse, Renner, Smalley, Stillwell, Young and Sferra.

GRADUATE COURSE

Dr. Renner, of the Post-Graduate Committee, described the new course which was to start in a few days and which promises to be a very instructive one.

E. R. A.

Dr. Stillwell, of the E. R. A. Medical Advisory Committee, reported that his committee had met with E. R. A. officials and had transacted all usual business pertaining to that committee.

FIFTY YEARS OF PRACTICE

Dr. Stillwell called the society's attention to the fact that Dr. J. A. Anderson, of Neshanic, N. J., was completing fifty years of practice, and he moved that the society officially take cognizance of this unusual event. A committee consisting of Drs. Stillwell and Flynn was appointed by the chair to draw up a proper set of resolutions.

PHARMACEUTICAL SOCIETY

Dr. Lawton called the attention of the society to a meeting to be held April 15th at Rutger's College of Pharmacy in Newark. This meeting is a joint meeting of the New Jersey Medical Society and the New Jersey Pharmaceutical Association. Dr. Lawton urged the members to attend this meeting.

ANNUAL MEETING

Inasmuch as our next meeting is the Annual Meeting, on which date there is election of officers, the chair appointed a Nominating Committee consisting of Drs. Stillwell, Brittain and Lawton.

SCIENTIFIC

Dr. S. B. English was the guest speaker of the evening. He gave a very interesting and instructive discussion of Childhood Tuberculosis.

Light refreshments were served at the close of the meeting.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

A largely attended meeting of the *Union County Medical Society* was held on the evening of April 10th at Muhlenberg Hospital, Plainfield, Dr. Edward S. Krans presiding.

ECONOMICS

Councilor C. C. Beling was present and spoke on varlous subjects, especially economic, affecting the welfare of our members.

THE STERILIZATION BILL

The society went on record as approving the passage of the State sterilization bill.

NEW MEMBERS

The following physicians were elected to membership: Neil Castaldo and Edward E. Terrell, of Cranford; William G. Gardine, Scotch Plains;

Charles Oderr, Westfield, Thomas F. Hunt, Elizabeth; Saul A. Naidorff, Plainfield; Robert O. Page, Rahway; and A. E. Tator, Summit.

There were also twelve proposals for membership to be acted on at the next meeting.

SCIENTIFIC

A very ably presented scientific program included the presentation of patients:

Gigantism, Dr. L. H. Leggett.

Treatment of Thrombocytoplenia and Pyrexia due to a Medication, Dr. Raphael Yood.

Carcinoma of Lung, Dr. J. A. Runnells.

Brain Tumor, Dr. Fitch.

Congenital Diaphragmatic Hernia and Congenital Atresia of Pylorus, Dr. L. H. Salvati.

Refreshments were served and a social session enjoyed after the meeting.

WESTFIELD MEDICAL SOCIETY

Reported by Frederick A. Kinch, M.D.

Meetings of this society were held as follows:

February 12th, speaker, Mr. Anton Hogstad, Jr., special assistant to the president, Merck & Co., Inc., who spoke on the "History and Romance of Drugs", particularly stressing on the discovery and history of cinchona and its derivatives in the treatment of malaria.

March 12th, Dr. George P. Olcott, of East Orange, told us of a treatment of diabetes using a full carbohydrate diet, a most interesting and instructive address.

Since the meeting of April 12 marked the 250th meeting of the society, a committee was named to plan a suitable observance, which was held on April 7th. Dr. Russell L. Cecil, of New York, Assistant Professor of Clinical Medicine, Cornell University, Assistant Visiting Physician to Bellevue Hospital, talked to us on the present status of foreign protein therapy. His remarks were followed by a general discussion of the subject by the members and guests present.

Fifty-two medical men from all parts of the county and state, and members of the society sat at dinner in the Shackamaxon Country Club. Music was by Dushanek's orchestra. Dr. Fiske Wood, President of the Society, acted as toastmaster, calling on Dr. Joseph B. Harrison, dean of our profession, for remarks about the organizing of the society.

Dr. George P. Olcott told some incidents of Dr. Cecil's early life, they being life-long friends.

Dr. Kinch read a brief historical sketch of the society.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular quarterly meeting of the *Warren County Medical Society* was held in the Elks Club, Phillipsburg, April 16, 1935, at 11 o'clock, with the following members and guests present: Dr. Herman Baldauf, Belvidere; Dr. G. W. Cummings, Belvidere; Dr. H. B. Bossard, Harmony; Dr. James Weres, Alpha; Dr. George Mills, Hackettstown; Dr. Lawrence Bloom, Phillipsburg; Dr. Guernery West, Phillipsburg; Dr. Charles Lyons, Phillipsburg; Dr. F. A. Shimer, Phillipsburg; Dr. Timothy Spillane, Phillipsburg; Dr. William Skinner, Washington; Dr. William Varney, Washington; Dr. J. M. Lemmon, Washington; Dr. Clyde Smith, Oxford; Dr. Edgar Lane, Bloomsbury; Dr. Homer Bloom, Easton, Pa., and Dr. B. M. Hance, Easton, Pa.

The meeting was called to order by Dr. Herman Baldauf, the President.

Communications from Dr. Beling, our Councilor, and Dr. Wilkes, the Executive Secretary of the State Medical Society, were read.

SCIENTIFIC

Dr. B. M. Hance, Chief of the Urological Staff of Easton Hospital, read a paper on endocrinology which was much appreciated by the members present.

HEALTH HOUR

Dr. Lawrence Bloom spoke on the *Health Hour* which is sponsored by the State Medical Society.

LEGISLATION

It was moved and seconded to send telegrams to our Assemblyman and State Senator asking them to not support the osteopathic bill No. A-238 which is introduced in the Legislature.

NEW MEMBER

Dr. J. M. Lemmon, of Washington, was then elected a member of the society.

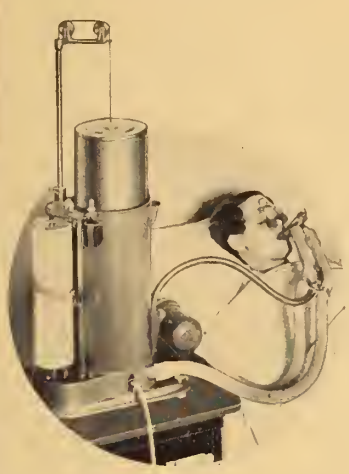
ELECTIONS

Dr. F. A. Shimer was elected a member of the Nominating Committee of the State Society in the place of Dr. F. W. Curtis, who will be unable to attend on account of illness.

Dr. G. W. Cummings was elected Alternate Delegate to the State Society for Dr. F. W. Curtis.

The meeting then adjourned.

Dinner was served in the Elks Club dining room.



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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

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Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Secretary—LeRoy A. Wilkes, M.D.

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Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

The Program of The Medical Society of New Jersey

The Annual Meeting of The Medical Society of New Jersey on April 30-May 2, 1935, is the culmination of two years of concerted action by its officers and committees, working in close contact with the County Medical Societies and their individual members. Practical methods of delivering medical services are now clearly apparent and are based on the actual personal experiences of family doctors rather than upon impersonal "studies" made by hired investigators.

Dr. Wilkes has used his intimate knowledge of the actual conditions of medical practice in New Jersey to formulate the principles on which a perfected system of medical practice may be developed in every community in New Jersey. He has clearly stated the enduring lines by which the present methods of practice may be extended by the family physicians themselves. His suggestion is that every County Society shall assert its leadership in all the plans for delivering medical service to those who are unable to purchase it for themselves. This involves the development of the *business* activities of every County Society, so that all other health organizations—both official and lay—shall look to its representatives for advice as to how to provide the services which they seek to promote. If the County Medical Societies will perfect their own business organizations, the solution of the problems socialized medicine will be attained in New Jersey.

The members of the County Societies already have knowledge of the principles of the proposed business methods; and therefore the first step in putting them into operation has already been taken. The next step will be the translation of the knowledge of the members into action, thereby putting them into effect. This step cannot come by legislation or mass action. It must come through the voluntary installation of business methods by each County Society. The principles will be adopted at first by a few societies whose leaders have the temperament to start a new course of action and perfect its operation.

The address of Dr. Wilkes is printed on page 380, in the department of State Society Activities. Read it and preserve it for continuous reference.

New Jersey at the A. M. A. Meeting

New Jersey will be host to the American Medical Association at its eighty-sixth annual session, which will be held in Atlantic City from Monday until Friday, June 10-14, 1935. This is the third visit of the A. M. A. to Atlantic City in sixteen years, it having met there June 9-13, 1919, and May 25-27, 1925.

This year's session will be the most extensive in its history, since the Canadian Medical Association will meet at the same time, and the scientific sections and the scientific exhibits will be under the joint auspices of the two organizations.

NEW JERSEY DOCTORS ON THE SCIENTIFIC PROGRAMS

The program of the scientific session fills eleven pages of the A. M. A. Journal of the May 11th issue. The names of 700 physicians are listed as participants, of whom seven are from New Jersey. Dr. S. R. Woodruff, of Jersey City, Chairman of the Section on Urology, will give the Chairman's address, his subject being "Metastatic Carcinomatosis of the Ureter".

Dr. W. B. Stewart, of Atlantic City, is Vice-Chairman of the Section on Pediatrics.

Drs. S. A. Cosgrove, Perry O. Hall, and W. J. Gleeson, of Jersey City, will give a paper with lantern slide demonstrations on the subject "Spinal Anesthesia in Obstetrics".

Dr. M. J. Fine, of Newark, will discuss the paper by Dr. Wright, of Montreal, on "Allergy in Childhood Tuberculosis".

Dr. H. B. Orton, of Newark, will discuss the paper on "Carcinoma of the Larnyx" by Dr. Norman Patterson, of London, England.

Dr. Julius Levy, Newark, will describe the state-wide health survey of school children as a C. W. A. project.

In contrast with the seven representatives from New Jersey, Pennsylvania has 83 speakers listed, and New York, 114 speakers.

In 1919 four New Jersey doctors read papers, and six took part in discussions.

NEW JERSEY AND THE SCIENTIFIC EXHIBITS

The scientific exhibits will be the feature which will attract the most widespread interest. There are 233 exhibits listed, of which four are from New Jersey, all having been shown at the last annual meeting.

Drs. John W. Gray, W. G. Barnhard, and C. H. Gowen, of St. Barnabas Hospital, Newark, will demonstrate chronic arthritis.

Drs. Manfred Kraemer and Maurice Asher, Newark, will demonstrate ulcerative colitis.

Dr. Raphael Pomeranz, Newark, will demonstrate the abdominal lymphatics.

The Medical Society of New Jersey will show the charts and literature which were demonstrated at the State Society meeting. Ours is the only State Medical Society which is credited with demonstrating its activities at the A. M. A. meeting.

New York is credited with 36 exhibits, while 61 are credited to Pennsylvania.

The comparatively small representation of New Jersey physicians on the scientific program and demonstrations of the American Medical Association is somewhat surprising in view of the fact that the percentage of physicians who support the A. M. A. by their fellowships or subscriptions to the Journal is larger than that of any other state,—65 for New Jersey, and 50 for the entire United States. (See the table on page 554 of this Journal of October, 1934.)

NEW JERSEY PHYSICIANS AS HOSTS

It is as hosts to the visiting doctors that the physicans of New Jersey will distinguish themselves. The Chairman of the local Committee on Arrangements is Dr. William J. Carrington, who keeps himself up-to-date by directing the arrangements for the annual meetings of The Medical Society of New Jersey.

The ladies of the National Auxiliary will be entertained by the State Auxiliary, and by the Atlantic County organization under the general chairmanship of Mrs. Samuel L. Salasin, who also has developed special skill through acting as host to the State Auxiliary.

The hundreds of New Jersey physicians who will attend the A. M. A. meeting are invited to use the exhibit booth of the State Society as an information center where they may leave notes for their friends, and receive messages. The Executive Secretary and the Editor will be on duty, ready to serve the members of the State Society.

County Society Bulletins

Ten of the twenty-one county medical societies of New Jersey issue Monthly Bulletins, to the edification of their members and the enlightenment of the officials and committees of the State Society.

The subject of Monthly Bulletins was discussed on May first, in the annual conference of County Secretaries and Reporters, and a paper on the subject by Dr. Brennock, of Hudson County, is printed on page 384 of this Journal.

A County Society Bulletin is a product of growth and evolution. It is an essential means of informing the members of the medical problems which they face locally, and of the measures taken by the physicians to meet the needs of their local communities. It supplements the general information and appeal contained in *The Journal of The Medical Society of New Jersey*, and reveals the interest shown by the local members compared with that shown in other counties.

There are good reasons that the Bulletin should be sent to every practicing physician in the county. This procedure would undoubtedly result in securing new members. The cost of the extra copies will be small and the money would be well spent.

Moreover, those members who cannot attend a meeting of the Society will be glad to receive information of the actions taken by the Society during their absence.

The Journal will take notice of items in the County Bulletin as addenda to the reports sent by the County Reporter. Information of the activities of every county society, large and small, will be an inspiration to the members of all the other county societies.

Standing Orders for Visiting Nurses

The question as to what a visiting nurse may and may not do before the doctor comes, frequently arises to the annoyance of both the nurse and the family doctor. An attempted answer to the question is the formulation and adoption of "Standing Orders" by the mutual agreement between the representatives of the official societies, the physicians, and the nurses. The standing orders specify what a nurse may do on her own initiative in the absence of the doctor, or before he is called or arrives. For example, it is usually agreed that a nurse may take the temperature and give the patient a bath. It is debatable whether or not she may give an enema unless a doctor prescribes it.

As a matter of fact, disputes, when they occur, usually arise from conditions which are personal and temperamental, rather than scientific.

In defense of the visiting nurse it may be argued that she is an emergency visitor who is expected to judge the seriousness of a condition which she finds, and to act accordingly. Some nurses are naturally apprehensive and impulsive, and feel impelled to "do something" for the patient at once without waiting for the doctor's orders. Others are optimistic and slow to act, and thereby delay sending for a doctor when conditions demand immediate action.

The doctor's side of the argument is usually that the nurse has given information or an opinion different from that expressed by himself. Sources of error of expression are numberless, and unavoidable, as our law courts demonstrate.

When temperamental conditions of either the nurse or the doctor are unfavorable, misunderstandings are probable; but when both the doctor and the nurse are unyielding in their opinions, trouble is certain. On the other hand, coöperation is almost certain to follow a friendly conference of the doctor with the nurse, and agreements between the medical leaders and the nursing organizations.

A collection of standing orders has been proposed by the State Committee on Nursing and Nursing Education, to be the constitution and by-laws of both the doctors and the nurses in their overlapping functions.

Honoring Maimonides

The June meeting of the Maimonides Medical League was a celebration of the 800th anniversary of the birth of Moses Maimonides, and was held in the Academy of Medicine of Northern New Jersey, 91 Lincoln Park, Newark, N. J., on June fourth.

Moses Maimonides was a devout Jew who was born at Cordova, Spain, March 30, in the year 1135. His father was a man of standing, a scholar and a writer, who gave his son every advantage of education. When the boy was thirteen years of age, his family, along with many others of his race, was expelled from Spain by the Mohammedans. After wandering for twelve years, the family went to Cairo, Egypt. There the son practiced medicine with honor among the Mohammedan people, who held him in high esteem as a philosopher and practitioner of medicine. He died December 13, 1204.

The reputation of Maimonides as a physician led an Arab poet to write of him:

"Galen's art heals the body;
But Maimonides', the body and soul.
With his wisdom he could heal the sickness of ignorance.
If the moon would submit to his art, he could cure her of her periodic defects."

The "eight degrees of charity" of Maimonides ends with a principle which is as new as that of the latest social legislation. "The eighth, and most meritorious of all, is to anticipate charity by preventing poverty. This is the highest step, and summit of charity's golden ladder."

The meeting will be reported in an early issue of the Journal.

The Speakers' Bureau

Less than a year's experience with the Speakers' Bureau has demonstrated that the project of the Woman's Auxiliary is entirely practical and useful. The reports of the County Auxiliaries given at the Annual Meeting of The Medical Society of New Jersey showed that ten of the fourteen auxiliaries had approved the plan and had put it into operation, with the County Medical Societies appointing speakers who are willing to give addresses on health topics to lay groups with whom appointments are made by the Auxiliary.

The essential part of the plan is that the representatives of the Auxiliary shall be the publicity agents for the Medical Society in the specific activity of health education. Nothing that borders on personal advertising is permitted by the voluntary code of ethics which physicians impose upon themselves. But the *Medical Society* is the impersonal embodiment of the *medical profession*, and what it does is for the benefit of its members as well as the public. The people generally are scarcely aware of the existence of the County Medical Society; and still less is it generally known that the Medical Society is ready to advise the *community* regarding public health matters, and to instruct them in methods for distributing medical services to those who through ignorance, or prejudice, or poverty, are unable to obtain medical attention. The Speakers' Bureau therefore fills a very necessary need of the community.

It is a natural evolution of the influence of the Auxiliary that it should join the Federation of Women's Clubs, and should offer an educational service which physicians consider to be necessary. The Speakers' Bureau is the first organized project to provide the opportunity for practicing physicians to educate the people regarding matters of health conservation as well as the cure of actual disease.

Publicity by physicians regarding *hospitals* for the *cure* of sickness has always been considered to be desirable. Physicians are now ready to take a further step and engage in publicity regarding *preventive* measures, and all other forms of service which only physicians can render.

Personal Normalcy

The contacts of human life are many and varied; and how we meet them determines our happiness and efficiency.

Psychiatrists are the present-day exponents of the ancient art of prophecy as they discover and interpret the hidden forces which impel the individual to a predetermined success or failure.

Between *fame* and *obscurity* there is a middle ground of *normalcy* in which the greater part of mankind is content to be classed. The ordinary individual seeks a level of normalcy with a few slight elevations of accomplishments from which he may gloat over the heads of his neighbors and be seen by them. If he does not actually have the outlook, he can enjoy imagining one whose top rises to heaven.

Every person measures his neighbors by what he imagines himself to be. The accuracy of his computations depend upon the degree of his normalcy.

The New York Herald Tribune of May 17th, reporting the proceedings of the American Psychiatric Association, gives seven tests of normalcy, by which a person may judge himself. Here they are, together with the editor's own answers regarding himself:

1. Do you think yourself beautiful?
   No, for our friends say, "That new hat looks good on you."
2. Do you believe you are healthy, efficient, and superior?
   Yes, or we would lose our job.
3. Would you beat up your bigger companions? In other words, are you aggressive?
   Yes, but our scathing diatribes end up in the wastebasket of the editorial sanctum, for all such bombshells are duds anyway.
4. Are you masculine, if a man, or feminine, if a woman?
   We admit that we are "uncertain, coy, and hard to please", for we have numerous letters to that effect.
5. What is your attitude toward sex and love?
   Birth control is not discussed in The Journal.
6. How much money each month would make you happy? In other words, how much do you expect from the future?
   Not much. Our happiness is homemade,—not bought.
7. Are you afraid of death?
   Yes, but we don't think about it.

The difficulty of applying these seven tests is the impossibility of looking one's self in the face. Get your neighbor to answer these questions for you.

This recalls the advertising sign in a trolley car, "Wear diamonds. Look prosperous. Write for our confidential terms."

The advertising agent said that this sign brought in fifty orders a month.

Doctors are optimistic. Their personal appearance of prosperity is an excellent example for their depressed patients.

Planning or Doing

The philosophy of Jane Addams, whose obituary appeared in the national press on May 22, will appeal to practicing physicians. Although she had been acclaimed one of the twelve most useful women of the United States by an impartial jury of competent judges for her "Hull Settlement House" in Chicago, the New York Herald Tribune said of her:

"She declined ever to prophesy the world's future or to lay down rules for its progress. She learned from *life* that there was no other way to learn, that there was no use in planning. All the world could do, she said, was to keep its eyes open, and to be ready for whatever experience might bring. 'After we have relieved men's hunger, perhaps we shall set ourselves to the task of finding out why they have failed to adjust themselves.' "

There are two ways of planning a medical service. One that has been followed by the great medical endowments is to support gigantic "Studies", made by hired investigators bent on establishing a preconceived idea, of what

men ought to be rather than what they really *are*.

The other method of planning is that of Jane Addams. She gave service to individuals and small groups who had particular needs and were willing to give a hearty acceptance to her specific services.

The Medical Society of New Jersey is following the plan of Miss Addams. The people of the state are in dire need of particular medical services which are clearly apparent. It has approached the solution of the problem through the path of individual service, which is exemplified in its two state-wide projects of the Emergency Relief Administration and the Public Health Hour.

The E. R. A. system enables family physicians to deliver medical services to their poor patients,—as they have always been willing to do, but could not because no means had been provided by which their poor patients might *utilize* their services. New Jersey has set an example of individual service which other states and the nation might well adopt.

The Public Health Hour is a concerted movement by which the services of preventive medicine may be delivered by family doctors without an elaborate machinery whose planning and operation would require far more effort and money than the actual delivery of the services by individual doctors.

It is true that the development of the two projects of the State Society will require a great amount of planning, just as does the diagnosis and treatment of every individual sick patient. But the planning is along the lines of a further development of the ancient and well-tested system of the individual practice of medicine.

When the grandiose plans of the promotors of compulsory health insurance are developed into a working system—if they ever are—the New Jersey method of solving the individual problems as they arise will have proved its natural simplicity and practicality.

Histories of County Societies

The presidential address of Dr. Ely at the Annual Meeting of The Medical Society of New Jersey was an inspiration for a study of the records of the establishment of the Society a century and a half ago. The founders encountered the same problems and faced the same difficulties which confront the medical profession today. The activities of the State Society in its early days have been exactly duplicated time and again; and scarcely a new method has been introduced in these so-called modern days.

The founders of the State Society, and those who carried on its work builded better than perhaps they realized. We are the inheritors of their prophetic insight, which led them to attack the problems immediately at hand, and to offer solutions which we have not succeeded in perfecting. The question of fees, for example, was discussed on the very day on which the Society was established, and its lengthy fee list has an extremely modern application.

Legislation too was carried on from the outset in exactly the same manner as today and with results equally as good. The system of county society reporters also was introduced early, and was operated with great success, as is shown by the preponderance of space devoted to their reports in the annual transactions.

What is lacking in medical history is the revelation of the humanity of the physicians a century and a half ago. They were as practical and as human as we modern doctors; they thought and acted the same as we do today. To discover their activities and reveal their motives requires a study similar to that of a bank examiner, who delves into columns of dry figures, and from them reconstructs the motives which actuated former depositors and investors.

The Publication Committee will encourage a study of the former records, and the resurrection of those who were unwittingly the makers of the system under which we now practice medicine. Knowledge has changed, but medical motives are eternal and everlasting.

ORIGINAL ARTICLES

CONSIDERATION OF GOITER

By John F. Hagerty, Newark, N. J.

Read before the Surgical Section of the Academy of Medicine of Northern New Jersey, April 23, 1935.

The treatment of goiter may be said to have reached a degree of perfection comparable to that of any other human ailment. As a result of the accumulated experience of many workers devoted to its study, the principles of treatment are well understood and the results highly satisfactory. It is unfortunately true, however, that many physicians still consider all forms of goiter alike and resort in all cases to the indiscriminate use of iodine,—a drug which is exceedingly helpful when properly given but which may do harm when not so used.

THYROID FUNCTIONS

Goiter, which is a general term used to describe a variety of disturbances of function of the thyroid gland, is a fairly common ailment, and is becoming increasingly so; and unless it is properly treated, may result in chronic invalidism or death. These results will be better understood if we recall that the gland produces a secretion containing iodine in organic form which, normally, regulates the growth and physical and mental activities of the body, but which when accelerated, produces a profound effect upon the system, causing alterations of function designated by the term *toxic goiter*.

The essential function of this secretion is to maintain the general metabolic rate of the body at its proper level. Tests made upon normal animals and upon thyroidectomized animals with thyroxine, the active principle of the secretion which was discovered by Kendall of the Mayo Clinic in 1914, proved its physiological activitiy, as shown by the increased nitrogenous excretion which followed its use. Hadden in 1882 had noticed a diminished excretion of urea in patients suffering from myxoedema—a disease caused by lessened activity of the gland—and that feeding the thyroid gland or active extracts of the gland caused an increased excretion of urea, accompanied by loss of weight. The increased excretion of nitrogen, implying an increased rate of metabolism, led Magnus-Levy in 1895 to study the effects of thyroid feeding upon the respiratory metabolism. It was found that feeding normal persons thyroid gland raised the rate of oxygen consumption, and that patients suffering from toxic goiter showed marked increase in the rate of oxygen consumption compared with normal persons. From these observations it was learned that toxic goiter was caused by hyperactivity of the thyroid gland and the value of the metabolism rate as showing the degree of activity of the gland was established. It was found, too, in experiments upon animals that excessive feeding of thyroid gland produced a condition resembling toxic goiter. Further study showed that all the effects of altered function of the gland could be measured in terms of reduced or increased metabolism.

Basal metabolism tests are perhaps the best means of distinguishing toxic goiter from all types of nervousness, and of determining the degree of toxicity. The test is helpful in differentiating toxic goiter from neuro-circulatory asthenia. But, it must be stated, the results are not always accurate. Not infrequently the rates are considerably higher than the clinical symptoms would indicate; and to one accustomed to seeing goiter patients the general condition of the patient, pulse rate, etc., prove to be the most reliable criteria.

The effects of reduced activity of the gland are: Accumulation of fat, resulting from diminished oxidation and excretion of waste products and from diminished physcal activity; anemia due to reduced hemato-poietic activity of the bone marrow, slowing of the heart rate and, indeed, of all physical and mental processes. These effects are due to the

retardation of all bio-chemical reactions upon which the normal processes of life depend. This constitutes the condition known as myxoedema.[1]

On the other hand, the direct reverse of this picture is presented by the condition of hyperthyroidism. Here we find a great increase in the metabolic rate, as indicated by rise in consumption of oxygen and excretion of nitrogen, with resultant wasting. At the same time all bodily processes are stimulated and proceed at an abnormally high rate, as shown by excessive nervousness. increased heart rate, sweating, thirst, polyuria and myaesthenia, and later, vomiting and diarrhea [2]—reactions, which when extreme, may cause death from exhaustion. This constitutes the condition known as toxic goiter or Graves' disease. The following instances may be cited:

Mrs. G. A., aged 31. U. S.; married, nullipara. Seen January, 1934. Had been ill since July, 1933. Father died a few months before. Very nervous since father's death. Very toxic. Exophthalmos, tachycardia, pulse 132, tremor, thirst and sweats. Lost considerable weight, oedema of extremities. Severe myasthenia. Neck, nodular tumor both lobes. Admitted to hospital—markedly excited, agitated, became irrational, difficult to restrain, rapid loss of weight. Exhaustion and death six weeks later.

Mrs. L. van Z., 41, married, one child 12 years old. No previous illness. Eight months before, father had fracture of the skull. Patient much upset by the accident, became very nervous. Exophthalmos, extreme tachycardia, pulse 180, loss of weight, thirst and sweats. Admitted to hospital December 1, 1929. Vomiting and diarrhoea set in soon after admission and despite treatment the patient died December 12, 1929.

IODINE IN GOITER

There had been from the earliest times a vague idea of the relation of iodine to goiter and the beneficial effect of giving iodine to goitrous patients had also been known; but its intelligent use began in 1891, when Halstead first described the compensatory hypertrophy which occurred in the residual tissue left after partial removal of the gland. It is interesting to note that neither Kocher, who reported in 1883, 103 thyroidectomies, and who first called attention to the effects of the complete removal of the gland,—which he described as Cachexia-Strumapriva,—nor Reverdin, who described the same post-operative effects, understood the pathology of the gland. These operations were done for the relief of pressure or for cosmetic effects. Halstead's discovery led to the study of the relationship of iodine to the pathological changes in the gland.

It was found that all normal glands contain 1.0 mg. of iodine per gramme of dried tissue; and that as soon as the iodine content falls below this value, hyperplasia becomes detectable. The significance of these observations was enhanced by the studies of Marine and Kendall, in giving and withholding iodine in experiments on dogs. They learned that restricting the supply of iodine led to glandular hyperplasia, and that this hyperplasia was exactly similar to that found in the residual gland left after partial thyroidectomy. It was also found that the hyperplasia of residual gland could be prevented by giving iodine; and also that the rapid involution of existing hyperplasia could be effected by giving iodine.

To sum up—the fundamental effects of iodine in the hyperplasia of Graves's disease is to relieve the relative deficiency of iodine and enable the gland to undergo involution with storage of colloid. This process occurs rapidly, and as the alveoli become distended with colloid, pressure retenton of the secretion occurs. This lasts until the glandular tissue has readjusted itself to the altered condition. Later, the gland again pours out its secretion at an abnormal rate, and the toxicosis persists or increases. This serves to explain the temporary beneficial effects of giving iodine in toxic goiter. With this knowledge of the effects of iodine upon the gland, proven by laboratory and animal experimentation and clinical observations, the treatment of goiter was placed on a definite, rational basis.

It has been shown then that the thyroid gland is essential to normal metabolic activities, that it has a definite secretion, and that iodine is an essential constituent of this secretion. Also, that a deficiency of iodine brought about in any way induces anatomical changes, viz: hyperplasia, etc.,—in the gland, to which the term "goiter" has been applied. When iodine is given, the stimulus to compensatory hypertrophy is removed and the gland undergoes involution. Recent observations have shown

the relations between the iodine in the blood and the iodine content of the gland. When the iodine content of the gland is low, that of the blood is high; and vice versa. This is due to the fact that the thyroid is converting every bit of available iodine to thyroxine as rapidly as possible, and is immediately putting this into the circulation, with the result that no active iodine remains in the gland.

Fortunately, the classification of goiter has been much simplified and the indications for the use of iodine are well understood. The American Society for the Study of Goiter has divided all types into four groups:

Nodular { 1. Nontoxic
2. Toxic

Diffuse { 3. Nontoxic
4. Toxic

It is to be regretted, however, that there is no way of determining the proper dose of iodine in any given case. It would be natural to conclude that mild degrees of alteration of function would call for small doses of iodine, and that larger doses would be indicated in severe toxicosis. It would seem also that the basal metabolic rate would offer a solution to the proper dose. This is only partly true, and this lack of definite knowledge of how to give iodine may explain the faulty, and often harmful, way in which it is given. It is to be hoped that a practical method of determining the blood iodine may be found, and that upon this knowledge the intelligent use of iodine may be based. Studies are now being made to determine the normal iodine curve of the blood. With this curve established, intravenous injections of iodine solution of calculated strength will raise the curve, depending on the amount of iodine in the gland. The chief characteristic of the gland is its avidity for iodine.

GOITER OF ADOLESCENCE

The treatment of simple goiter, or the goiter of adolescence, has been clarified by the work of Marine and Kimball, who in a series of studies on young school girls approaching puberty, not only showed the beneficial effects of iodine in those in whom the thyroid had already become enlarged, but also the preventive effects of giving small doses of iodine before the onset of menstruation and the appearance of goiter. So satisfactory and conclusive were the results of this plan of treatment, proving that the increasing demands upon the thyroid by the rapid growth and development of girls during that period, called for an increased supply of iodine, that their methods have been universally followed, and in Switzerland, where the percentage of goiter cases was very large,—in some districts almost 100 per cent,—the administration of iodine has reduced the incidence of goiter very markedly.

These clinical experiments proved so effectively the benefits of iodine in preventing goiter that iodine prophylaxis is now routinely practiced in all goitrous districts. These results are brought about in two ways; first, by the use of iodized salt in the preparation of foods; and, secondly, by giving small doses of iodine for stated periods to school children approaching puberty. The form in which iodine is given is not important. But it should be emphasized that only small doses are necessary, and for a short period of time, as a rule, to secure the desired results. Lugol's solution gtt ii 2, representing 10 mg. of iodine, given once a day for a few weeks, and longer if necessary, or chocolate-coated tablets of iodostarine (Roche) equivalent to two drops of Lugol's solution, may be given; or Sod. Iodidi gr. ¼; or Syr. Ac. Hydriodici; and to frail, delicate girls, cod-liver oil given over a long period may accomplish the same result. It is never necessary to give large doses of Lugol's solution, nor to continue it indefinitely, as great harm might result. Nor is it necessary to resort to other forms of treatment, such as x-ray, electricity, light treatment, etc. Attention should be paid to the general health and habits of these children and to allaying fear, both in the patients and their parents.

NODULAR GOITERS

The treatment of nodular non-toxic goiters and toxic goiters is practically identical. The former are usually unilateral, not infrequently found just above or below the sterno-clavicular joint, or above or below the supra-sternal

notch; and in all these locations, unless large, may be overlooked. Standing in front of these patients and directing them to swallow, will often show small adenomata which were not suspected. These nodular goiters may grow to considerable size and undergo degeneration of different kinds, viz: cystic, fibrous, hemorrhagic, with calcareous deposits; or, there may be multiple nodules in one or both lobes, or multiple cysts of varying size, so that at times the entire gland is replaced by cysts, small and large,—the so-called tapioca pudding gland,—or these cysts may coalesce and the lobes be almost completely destroyed, leaving only the capsule of the gland as cyst-wall.

These adenomata are usually small, but may grow to considerable size and cause discomfort by pressure, or annoyance by their unsightly appearance. Depending on their position, they may cause pressure on the trachea and oseophagus, or on the recurrent laryngeal nerve producing dyspnoea, dysphagia, or aphonia. But most important of all, however, is the fact that after the lapse of years these tumors may undergo malignant changes, jeopardizing the patient's life and often causing death. Experience has proven that carcinoma of the thyroid always develops upon pre-existing adenomata, especially foetal, and it is the opinion of all who are interested in this work that these growths, no matter how small or inoffensive, should be removed. All goiters of long duration that have suddenly increased in size, or that have lost, even slightly, their mobility, should be removed, and x-ray therapy applied. Fortunately, x-ray therapy is especially favorable in these cases, due as claimed by some to greater radio-sensitiveness, and possibly because of their accessibility to treatment.

DIFFUSE NON-TOXIC GOITERS

Diffuse non-toxic goiters, so-called *endemic goiters,* of which the large colloids furnish a good example, are without systemic effects. They are not amenable to medical treatment, iodine having little or no effect; and, if causing pressure or annoyance by their appearance, should be removed. It must be remembered too, that areas of hyperplasia may be found in colloid goiters, explaining the toxic symptoms often observed in these patients. Operative removal is almost entirely free from danger, and the reaction following operation is slight.

TOXIC GOITER

Toxic goiter, whether of the nodular, or diffuse type, is a very serious ailment, and demands the most intelligent care. While it must be admitted that the etiology of the disease is not definitely understood—whether the hyperthyroidism is due to the action upon the gland of some extrinsic agent or due to disorganization of the gland itself, the treatment has been crystallized during the past few years. And, until it becomes known what initiates the overactivity of the gland with all the train of systemic disturbances which cause severe invalidism and at times death, *surgical removal,* more or less complete, offers the only practical method of dealing with the disease.

The limit of time precludes discussion of forms of treatment other than surgical. Competent roentgenologists report satisfactory results with x-ray therapy, but the results cannot be predicted and the treatment involves considerable time and expense. These patients should not be subjected to operation until their toxicity is reduced to the lowest possible level, and their ability to stand the shock of thyroidectomy raised as much as possible. This condition is brought about by the administration of iodine.

PREPARATION FOR OPERATION

It is very interesting and gratifying to see how quickly severe toxicity, as evidenced by extreme nervousness, tachycardia and loss of weight and strength, can be overcome by its use. Means and Lerman[2] say: "So constant and specific is this response that we have come to regard it as one of the cardinal manifestations of the disease. When it does not occur, we are always doubtful of the existence of thyrotoxicosis." Especially is this so if these patients have not been taking iodine in irregular doses and over long periods of time. It cannot be too strongly emphasized, however, that iodine alone will not cure these cases. Not only that, but if given in excessive doses or too long continued, it may not only aggra-

vate the condition, but may make operation dangerous or impossible.

It is true that many competent observers deny the possibility of iodine-induced goiters, but our experience has been discouraging in the effort to bring cases so treated into operable condition. In such cases withholding iodine for several weeks will enable preparatory treatment to be resumed. In diffuse toxic goiter the dose should be proportionate to the degree of toxicity and this dose may be increased or even doubled twenty-four hours before operation to prevent postoperative crises. We are not certain of the value of this method but have tried it satisfactorily in some cases.

In the management of toxic adenomas, our own experience corresponds with that of most observers, that the reaction to iodine is not as uniformly favorable as in those of the diffuse toxic type. Indeed, the tachycardia and nervousness are often increased by its use, even in moderate doses. In these cases the effects of the remedy have to be studied and the dose regulated. Sedatives may be given in larger doses. While admitting that the results of medication are apt to be variable, and this may be due to areas of hyperplasia in other parts of the gland, rest and sedatives and changing doses of iodine will bring amelioration of symptoms in the majority of cases.

In general, the principles of treatment are the same for both types. These are: rest in bed, abundance of carbohydrates and fluids, sedatives, preferably luminal, to allay nervousness and fear and induce sleep; securing the confidence of the patient, and giving iodine (Lugol's solution) until the general condition is improved. By this is meant loss of restlessness, agitation and fear, and pulse rate ranging about 100 or less. This favorable condition can be brought about in one or two weeks in the average case, and subtotal thyroidectomy may then be done. It is never fully possible to say how much simple nervousness aggravates the toxic effects, and recently we have been encouraged to operate on some patients with more rapid pulse rates but whose general condition seemed to warrant operation. Here, judgment guided by experience must govern the decision to operate.

THE OPERATION

The question of anesthesia would seem to be a matter of individual choice. For several years we have relied entirely upon local anesthesia, using novocaine 0.5 per cent solution with a minute quantity of adrenalin, and with almost complete satisfaction. The novocaine solution is used freely by infiltration, and after reflection of the skinflaps, is injected submuscularly before ligating the superficial vessels. We have never observed any toxic effects from novocaine, although occasionally patients become very restless after infiltration, and the pulse rate increases rapidly, at times becoming arrythmic and fibrillating. We have seen pulse rates of 220 and, frequently, 200. This effect is due partly to apprehension, at times we believe to adrenalin, and possibly to both. When it does occur, operation is postponed, to be tried again after a week or ten days. In nearly every instance the patients have borne the second operation well. Sleep is secured the night before by luminal. Nembutal gr. 3-5 is given three hours before operation, and morphine gr. ¼ with atropin gr. 1/150 is given a half hour before operation.

Whether to do lobectomy or subtotal thyroidectomy may be decided, in most cases, before operation, but will often have to be decided at operation, and will depend on the reaction of the patient as the operation proceeds. If not very restless and the pulse rate does not rise much after partial lobectomy,—and usually there is a drop in the pulse rate,—complete operation may be done.

The question of how much gland to remove is a serious one. Of course, recovery of the patient from the operation will be the compelling argument, but patients are often discouraged to learn that they have to undergo a second operation. After all, when to operate and how much of the gland to remove must depend on the judgment of the operator and this judgment is based on experience.

AFTER-TREATMENT

Immediately after operation these patients are given tap water, one pint, with Lugol's solution, in doses depending upon the individual case, per rectum. Morphine sulphate gr. 1/4 without atropin, is given hypodermically, and glucose solution, 5 per cent, is given intravenously, the quantity depending upon the severity of the case. As a rule, 2000 c.c. are given the day of the operation, and this may be repeated on the second day. We have frequently given considerably more and in very severe cases give solutions continuously for twenty-four hours.

It has been our experience that the maximum effect of removal of the gland is felt on the evening of the second day. The system then seems to adjust itself to the reduction of secretion, and beginning with the third day patients usually improve steadily and treatment is given accordingly. Following the operation, where the tachycardia is severe and the heart is fibrillating, digalen minims 15 is given hypodermically every three hours, to be discontinued as soon as fibrillation ceases and the rate is reduced. When the temperature rises to 103.5°, we have found great benefit in reducing the temperature and allaying restlessness by surrounding the patient with ice bags, eight or ten in number.

It is a great tribute to the more intelligent use of iodine in the preparation of these cases that so few postoperative crises, formerly quite common, are seen. Water is given shortly after the operation. Difficulty in swallowing is often experienced during the first two days, and the voice sounds may be considerably changed but, as a rule, these changes disappear after a few days. Fluids, fruit juices and soft diet are then given. We are not convinced of the necessity of iodine immediately after the operation, nor of the correct dose to give. Most often iodine is not given for several days, and then Lugol's solution is given two or three times a day to prevent compensatory hypertrophy, and continued for several weeks. Contrary to the experience of most observers that iodine is useless postoperatively, we have found it extremely helpful in preventing compensatory hypertrophy, or in removing it (causing involution) when recurrences do take. Not only that, in cases of mild hyperthyroidism, Lugol's solution in small doses (gtt. 2) once or twice a day, given over a long period has effected a cure or checked the progress of the case.

Mrs. C., aged 24 years, married, one child one year old. Shortly after she became nervous, had tachycardia, tired on exertion, lost weight, and B. M. R. showed readings of plus 27 and plus 19. An operation had been advised. Rest was enjoined, and avoidance of excitement and stimulants, and Lugol's solution gtt. ii 2 was given. She improved steadily, and after one year again became pregnant. She was under observation during second pregnancy, taking Lugol's solution, and was delivered of the second child without any aggravation of the goiter. At present she is well.

Recurrences following thyroidectomy more or less complete, are fairly common and are very discouraging. Whether due to persistent hyperthyroidism, insufficient removal, or to the effect of some extrinsic agent, viz: adrenals, is not certain. The possibility of predisposition or tendency to lymphoid hyperplasia must be considered. Why, after all, should one member of a family develop toxic goiter and not another; and if partial thyroidectomy is done, why should not recurrence take place unless all stimuli leading to hyperthyroidism are removed and sufficient iodine be taken? Whatever the cause, these patients should be freed from all psychic irritation and given iodine as soon as recurrences appear.

RELATION TO GLYCOSURIA

The occurrence of glycosuria in toxic goiter should be emphasized. Care should be taken to determine the degree of glycemia; and with our present knowledge of control with insulin, operative removal of the toxic goiter can be safely undertaken. The experimental work of Frazier and Frieman on liver glycogen restoration[4] shows the harmful effects of ether anesthesia in these cases and the great benefit of intravenous injection of glucose solutions. They say "that thyroid hormone can effect a reduction or even depletion of the liver glycogen is now more or less generally accepted * * * the importance of anaesthesia and other

factors which still further deplete the liver glycogen and prepare a fertile soil for serious hepatic degeneration, must be kept constantly in mind. An operation for hyperthyroidism without question throws an additional load on glycogen stores which are reduced in severely ill patients." Therefore, the value of attempting to restore the liver glycogen by the judicious dose of carbohydrates immediately after the operation. The intravenous method offers the most rapid means of doing this in patients very ill after operation.

TACHYCARDIA

Tachycardia is the most constant symptom of thyrotoxicosis. Indeed, it may be the only symptom present. Hyperthyroidism without palpable enlargement of the gland is fairly common, although at operation small adenomata may be found when not suspected and the gland may be larger than thought, because of its deeper situation. Exophthalmos may or may not be present even in severe toxicosis, and, if patients are resting it is not uncommon to find that they have gained weight. Tachycardia is, at times, very severe and, if of long duration, myocardial changes develop, as shown by oedema of the extremities and arrythmia and fibrillation. When present, toxic goiter should always be thought of and especially if no improvement follows treatment. Digitalis has no effect in reducing the rapidity of the heart rate and rest alone has but slight effect. Iodine, together with rest, is the only remedy affecting tachycardia, and thyroidectomy offers the only hope of permanent cure. It is not always easy to differentiate tachycardia of thryotoxicosis from neuro-circulatory asthenia; but the presence of goiter, loss of weight, thirst, sweats, etc., would exclude the latter, while in neuro-circulatory asthenia, position alters the pulse rate. Resting and sleep lower the rate, while this is not true of toxic goiter; and basal metabolism rates, already referred to, may help to differentiate.

Whether the myocarditis be due to toxicity or to degenerative changes from over-strain of long duration, the relief obtained from thyroidectomy in progressive cardiac failure, if not too far advanced, is very gratifying; and we have seen many apparently hopeless cases restored to usefulness and to comfortable condition by the operation. It is not always easy to determine whether the signs of chronic heart failure are due to long standing toxicosis, or to independent cardiac disease, but the former class, if given careful preparation and consideration as to their ability to stand the shock of operation, often do surprisingly well.

TOTAL THYROIDECTOMY

Total thyroidectomy, as an aid in the treatment of intractable heart disease, is now being tried. It was suggested by Blumgart and Levine, of Boston, on the theory that lowering the basal metabolic demands of the body would lessen the work of the heart; and this belief was supported by the splendid results obtained in cases of cardiac disability due to thyrotoxicosis. While the operation is attended by considerable risk, successful results have been reported in a fair percentage of cases. Drs. Danzis and Polevski presented a few month ago a report of four cases operated on, with one fatality, and three cases moderately improved. Whether the dangers of the operation and the possible serious after-effects may outweigh the good to be obtained by the operation, sufficient time has not elapsed to tell. Dr. Henry A. Christian's judgment on the operation[6] is well worth considering. "Removing thyroid tissue has no known influence on the pathologic changes in the heart, and the care of cardiac cases with artificial induced myxoedema will require no less skill in their management."

MALIGNANCY

The development of malignancy in apparently inoffensive nodular goiters is of such relatively frequent occurrence and of such serious import as to be worthy of further reference. In a paper read at a symposium on cancer, in our Academy, during the past year, we reported 18 cases among 500 operated on. Since then we have met with four other cases. The consequences are so very serious, should malignancy develop, and the safety of removal of these growths is so great, that it is questionable whether this should not be done in every

case as soon as seen. We have been inclined to temporize because these growths are small and causing little inconvenience, yet the conviction of men having large experience, that malignancy always develops on preëxisting adenomate, should impel us to advise removal at once. It must be emphasized, too, that malignant changes may develop after many years.

George W., 57, had enucleation of large cyst adenoma, in 1922, which had been present several years. He remained well six years, then had local recurrence. At second operation, carcinoma of the right lobe invading capsule was found. Recurrence took place rapidly: trachectomy had to be done, and death took place one month later.

One of our cases of cancer of thyroid had had nontoxic adenoma thirty-two years.

Recently Mrs. DeV., aged 32, otherwise healthy, came to us with nodular non-toxic goiter, size of a walnut, which she had had ten years. The tumor was attached to trachea but slightly movable, and at operation was found to be adeno-carcinoma. X-ray therapy was immediately instituted but recurrence appeared in two months and x-ray pictures of chest showed many nodules in the mediastinum.

Mrs. Margaret M., aged 53, had thyroidectomy in 1920 by Dr. E. In 1924 she had recurrence. Was markedly toxic; developed psychosis. Was irrational two months. Lobectomy was done, and after a slow recovery patient remained well and at work until this year. In January, on examination, a cancer of the left lobe, cancer of the right breast with extensive involvement of the axillary glands, and cancer of the sternum, were found.

Pemberton, of the Mayo Clinic,[5] says, "Since there are no clinical signs to indicate malignancy in 50 per cent of all operable cases, and since there is no assurance that a tumor of the thyroid is benign, * * * and in view of the low operative risk, I believe we should urge removal of all tumors of the thyroid gland."

PREGNANCY

The influence of goiter on pregnancy and the foetus is an interesting problem. Non-toxic goiters, either nodular or diffuse, are not affected much by pregnancy nor do they have much effect upon pregnancy. The increase in the size of goiters at such times may be controlled by the judicious use of iodine. Removal of the goiter may be done, if enlarging rapidly or causing pressure effects, but not because of any influence on the pregnancy. In toxic goiters, too, iodine should be given in doses, graduated as the pregnancy advances, and where the toxicity is increasing. In the great majority of cases, these patients can be successfully carried through their pregnancy. Where the toxicity is extreme, and iodine and rest are not bringing relief, removal of the gland may be done. It is better, where conditions warrant interference, to remove the goiter than to interrupt pregnancy.

In conclusion: While it is earnestly to be hoped that the exact cause of toxic goiter may soon be known, and that less dangerous and more conservative treatment be established, yet in the present state of our knowledge, its successful treatment depends, in the majority of instances, on the surgical removal of the greater part of the thyroid gland. This must be done when the toxicity has been reduced to the lowest possible level.

The prevention of recurrences depends on the avoidance of severe mental and physical strain for several months after operation, together with the administration of small doses of iodine, which may be increased as soon as evidences of compensatory hypertrophy appear.

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RESECTION OF INTESTINE THROUGH FEMORAL OPENING

Joseph A. Visconti, M.D., LL.B., Hoboken, N. J.,
Associate in Surgery, New York Post-Graduate Medical School, Columbia University;
Attending Surgeon, St. Mary's Hospital.

From the Surgical Service, St. Mary's Hospital, Hoboken, N. J.

SUMMARY

This case is interesting from many viewpoints.

1. It demonstrates the unusual resistance that the body may sustain against the forces of destruction.

2. That gut resection and end to end anastomosis can be done through a hernial wound.

3. That every diseased condition should be considered serious until cured. In this case, attention was focused on the abdomen, when the wound infection starting as a relatively simple matter, lead to general septic conditions that almost defeated the major endeavor.

4. That blood transfusions are of inestimable benefit in building up and maintaining body resistance.

5. A relatively simple removable surgical femoral hernia may lead to the gravest complications, and perhaps death.

This patient showed a remarkably tenacious hold on life, overcoming numerous complications, any one of which might have been fatal.

W. B., aged 43 years, a truck driver, was admitted to St. Mary's Hospital, Hoboken, New Jersey, via Clinic, February 2, 1934.

The pertinent history is as follows: He had had a right femoral hernia for the past five months. On January 31st, three days before admission, while attempting to lift a heavy case of paper, there was felt a pain in the hernial area. This was followed by immediate swelling and enlargement. It became hard, and thereafter did not lose its consistency. For the next three days, he had recurrent attacks of vomiting, persistent pain, crampy and colicky in character, with little or no relief afforded by hypodermic ministrations of morphine. No bowel movement occurred during this period. Daily and bi-daily enemas were given, which were ineffectual. These treatments were administered by his wife, who claimed to be a nurse, and who realized the futility of her efforts after three days. It may also be added, that to add insult to injury, catharsis was given on the first day of this unforseen happening.

On admission, physical examination confined particularly to the abdomen and right groin, showed a sizeable irreducible, hard, tense, tender and reddened swelling, occupying the femoral area. The abdomen was distended. Peristalitic waves were visible during the painful spasms. There was much belching of gas also.

The blood pressure was within normal range, the pulse was accelerated to about 100, and the temperature was subnormal.

A diagnosis of strangulated right femoral hernia was made and in due course preparation for emergency operation was made.

Operation: Under ether anaesthesia, a Hockey Stitch Bassini incision was made over the swelling. The hernial sac was identified. The neck was so constricted that Poupart's Ligament was niched in order to free it. The constriction divided, the sac opened, a loop of bowel was drawn down so that the line of constriction could be inspected. The gut was flaccid, collapsed, discolored, and black, the mesentery was pulseless. There was blood-stained fluid in the sac. The suspected loop was wrapped up for about three minutes in hot pads. Its vitality was so doubtful that its return to the abdomen was inadvisable. Such was the unanimous opinion of three attending the operation. Sufficient intestines was drawn down through the hernial neck in order to permit resection of about ten inches, and subsequently, an end to end anastomsis. The usual operative sequence was observed: 1,

There was mobilization, by teasing the gut into the open operative field; 2, isolation, by means of pads; 3, segregation by rubber-covered clamps; 4, hemostasis, by tying off the blood vessel loops in the area to be resected; 5, excision of affected bowel; 6, reconstruction of proximal and distal cut ends of intestine.

The reconstructed loops were gently teased back into the abdominal cavity without too much tension on the suture line. Poupart's Ligament was then repaired. The femoral canal was closed with a purse string suture, beginning at Poupart's, coming into the opening, then a biting through the falciform process coming through Gimbernat's, then taking a good bite into the pectineus muscle, and lastly coming back through Poupart's to the point of beginning.

Insofar as the reconstruction of the intestinal canal was concerned, progress was stormy, but favorable during the first five days. There was no undue distension, or occasion for alarm. However, on the sixth day he was taken with a chill. Inspection of the wound revealed evidence of infection. Sutures were removed and emission of purulent discharge occurred, which continued to increase and become copious thereafter.

The intestinal current was securely restored, abdominal distention had been absent, bowel movements became natural, enemas became unnecessary. Recovery progressed uneventfully, save for wound infection, until the sixteenth day. Up to this time the temperature and pulse were within normal limits. Appetite was good, soft diet was being given. Bowel and bladder movements were normal.

On the sixteenth day, the clinical picture made a sudden unheralded change. Patient complained of low abdominal and groin pain. There was a sudden severe chill, fever up to 102, then up to 105. Profuse diaphoresis followed. The face became cyanotic, pulse rapid and thready. There was much hiccoughing, and patient became harassed by an unproductive cough. The wound was still discharging purulent matter. Urinalysis, for the first time, showed two plus albumin, many hyaline and granular casts. Blood count: R. B. C. 3,420,000, Hb. 60 per cent. W. B. C. 14,600. Polys 79 per cent, Lymphs 19 per cent, Mons and Trans 1 per cent, Eosinophiles 15. Sputum was negative to tubercle bacilli. Blood culture was negative.

Physical examination made about February 17, 1934—Chest: Moist râles distinctly audible at both bases posteriorly. Abdomen: Not distended, no definite areas of tenderness or rigidity, operative wound still discharging considerable pus.

It was now definitely concluded that the abdomen could reasonably be excluded as the seat of the present offending pathology. X-ray of chest was negative to Tb. fluid or consolidation, on February 22nd.

From February 16th until March 1st, 1934, the clinical picture consisted of several daily chills, fever, and sweats. On March 1st, it was noticed that the right arm was swollen and tender, and that the right thigh and leg were also markedly swollen and tender. A phlebitis of the lower extremity later became evident. At the same time the operative site continued to discharge copious amounts of purulent exudate.

Transfusion of 500 c.c. were given. Chills, fever and sweats continued. Three more transfusions were given. Chills became less frequent until April 7th, two days after the date of the last transfusion, when he became free of chills, fever and sweats.

After April 17th, the seventy-fourth postoperative day, temperature became slightly elevated, and he complained of pain in the region of the right ankle, and pain and swelling along the inner aspect of the right leg below the knee. A tender fluctuating mass was felt. X-ray revealed periostitis. This was the seat of an old periostitis that he had years prior to the present illness. An abscess developed. It was incised and drained. This cleared up as well as the operative wound infection.

On May 14th, he was allowed out of bed. On the one hundred and seventh postoperative day, May 20, 1934, he was discharged as cured.

He was last seen on Columbus Day, October 12, 1934. He was viewing the parade and hailed me as I marched by. He appeared healthy, robust and strong.

THE PANCREAS AS A BLOOD PRESSURE REGULATOR

By Harry Halprin, M.D., Caldwell, N. J.

A further study, supplementing a preliminary report in this Journal of January 1934, page 28.
Read before the Staff of the Mountainside Hospital, January 8, 1935.

The study of hypertension and the effect of different substances and physical states upon the blood pressure will always be of interest to the clinician because it immediately suggests the many unsolved elements which enter into the pathology of this condition.

This paper is devoted particularly to the results that have been obtained by using a special preparation of an extract of the pancreas to relieve symptoms and physical signs of an elevated blood pressure, and thus afford to the sufferer a longer and more comfortable life. A preliminary report on the pancreas as a blood pressure regulator was read before this group in January, 1933, and later published in the Journal of the Medical Society of New Jersey. This present paper will supplement the findings of the earlier one through the experience of additional cases.

Before presenting these further observations, it may be well to state that we have succeeded in making the extract more palatable. Max Lowenthal, who has been preparing the substance at the laboratory of our hospital, found that by further evaporation of the extract he could concentrate it so that it may be preserved in gelatinous capsules, each of which is equivalent to twenty grams of the fresh pancreas. The capsules keep better, are more easily handled, and more readily taken than the extract in its previous form.

Approximately fifty more patients have been treated. There were more females than males; the ages were from 39 to 64; they were all of the white race; and their blood pressure readings when first seen varied from 160/98 to 310/210. Eighteen of these were ward or clinic cases, and the remainder private. Of the private cases sixteen were patients of my own; the others were treated by different physicians under their own supervision, but all essentially followed the directions and dietary regimé as outlined in my original report.

For the purposes of this paper let us define as abnormal a sustained systolic blood pressure of 150 mms. or over; or a sustained diastolic pressure of 90 mms. or over. These figures are considered abnormal by many writers, and are generally accepted as denoting hypertension.

It becomes very important for this study to distinguish two types of cases:

a. Early hypertension, i.e., before degenerative processes have supervened, when there is simply a hypertonicity of the arterial wall or so-called *essential hypertension* or, as it has been called by some authors, a state of *angiospasm*.

b. Late hypertension accompanied by arteriosclerosis, which is associated with a true *degenerative process*.

ESSENTIAL HYPERTENSION

Essential hypertension is an elevated blood pressure; and it usually implies that its cause is unknown. Clinicians agree that one cannot treat successfully a disease whose etiology is unknown. The conceptions on which the present therapeutic guide is based are:

a. *Essential hypertension* is a functional disturbance of the vasomotor system due to a slow activity of the pancreas, hypopancreatism.

b. *True hypertension* is a condition where the same processes have become fixed due to continued and prolonged vasomotor disturbances of the same type. This implies that the elevated blood pressure of essential hypertension can be treated only by stimulating the pancreatic secretion or by replacing a lack of pancreatic substance and rearranging the dietary regimé of the patient so that the proper medium is provided for this substance to act upon. It is needless to say that such activities of hypertensive influences as nervous and physical strain must be lessened.

Irrespective, however, of whether increased blood pressure occurs in the predegenerative or in the degenerative state of the blood vessels, the general nervous symptoms are:

1. Fullness and sense of distension in the head, more marked during mental work, and

causing, consequently, an inability to concentrate and to continue the mental effort.

2. Dizziness and drowsiness.
3. Noises in the head, which increase when the patient lies down.
4. Attacks of pain in the head.
5. Gradual impairment of memory.
6. Development, as the disease progresses, of an emotional state marked by fear of impending danger and intense anxiety.

Following this preliminary group of symptoms, or in the midst of them, insults of apoplectic character may occur. They consist of intermittent temporary or transient attacks of hemiplegia or monoplegia. Sometimes there may be repeated attacks of parasthesia on one side, and each sensory attack usually leaves a slight feebleness on the same side. The latter train of events is caused by spasms of some of the small cerebral vessels.

Objectively in the very mild cases, one may find only a difference in the dynamometric measurements in both hands, or a slightly increased petellar tendon reflex on the affected side. The plantor reflex gives no response on the affected side, and contrasts strikingly with the prompt flexion of the toes on the sound side, or it manifests a distinct extension.

An enormous number of observations have been made on the chemistry of the blood, urine, and even tissue in connection with hypertension and arteriosclerosis. There is no proof that chemical changes have any bearing on the etiology of hypertension, though they may be of great importance in connection with the mechanism of the disorder. Abnormal sugar metabolism has been investigated by a number of oservers as a possible cause of hypertension, and it is the opinion of all that glucose, uric acid, and cholesterol are not "pressor" substances and cause no elevation of pressure when injected into animals. A decline in glucose tolerance is noted in certain cases of hypertension.

It is the contention of this paper that the pancreas, besides its proteolytic enzyme action, besides its Islands of Langerhans and their action of insulin on the carbohydrates, also serves to *detoxify the products of decomposition absorbed from the intestinal tract.* These products have pressor qualities and may cause spasm of the vascular system, which in turn leads to permanent hypertension. The detoxification of these products of digestion makes them more permeable to the kidney glomeruli, and the excretion of these products, as well as the water filtration, as evidenced by decrease of nocturea, is markedly improved with resultant improvement of the pressure.

Charts Nos. 1-4 are typical records of some of the patients treated with the pancreatic extract.

It is important to remember that the initial drop in pressure will not begin to manifest itself for at least two or three weeks and further, that the initial drop may be more pronounced than the subsequent gradual fall in pressure; that a gradual rise from that initial drop is to be expected; and that the blood pressure will finally stabilize itself and will not go below that minimum level.

Since it has been shown that the extract has a tendency at times to lower the blood sugar, it is of the utmost importance in the treatment of an old hypertension with definite arteriosclerosis and a history of coronary spasm, to insist on the high carbohydrate diet, because lowering the blood sugar in these cases below even a high normal will precipitate anginal seizures, which may prove of very serious consequence.

EFFECTS OF SPINAL ANESTHESIA

In cases of *extreme hypertension,* i. e., those exhibiting prodromal signs of oncoming apoplexy, especially with a history of long standing hypertension, a marked occipital headache, dizziness and perhaps vomiting caused by central irritation, we instituted emergency therapy following a report in the Journal of the American Medical Association (1933) by Dr. Albert S. Hyman, of New York.

The depressor phenomenon of spinal anesthesia so far as it relates to clinical blood pressure has long been known to surgeons. Dr. Hyman found in a study of 3000 spinal anesthesia records made in 1931 that it was demonstrated that a drop in both systolic and diastolic blood pressure levels occurred in about 92 per cent of all surgical cases in which spinal anesthesia was employed. This fall in

pressure averaged from 10 to 38 mms. of mercury in most of the patients exhibiting no cardiovascular disease. In individuals with high blood pressure levels, however, the depressor effect of the spinal anesthesia was more marked. With certain exceptions it was found that the higher the systolic level, the greater the fall in pressure. Such drops in systolic pressure may be quite extreme. In practically all the cases with a preoperative systolic level of 220 and above, there was a drop of 50 or more of pressure.

With this report in mind, we combined the work of Dr. Hyman with our own work with the pancreatic extract, having for our goal a sudden dropping of the systolic pressure in those extremely sick patients who were in the prodromal phases of cerebral hemorrhage, and then trying to maintain that pressure at the lowest possible level.

We were not overlooking the importance of venous section, which may at times be life-saving; but the secondary anemia frequently associated with this condition may be greatly increased by the removal of large quantities of blood. Moreover, the actual fall in systolic blood pressure, even with the removal of 500 to 1000 cc. of blood, is not very great. Any method that will cause a rapid drop of pressure without actual loss of blood volume, unless such procedure is desired from the standpoint of relieving heart failure, should be considered.

We treated six cases by spinal anesthesia. They all had systolic pressures varying from 200 to 260, and diastolic pressures of 110 to 160. Their symptoms and complaints warranted drastic measures. They all received 70 mgs. of neocaine. In four of theses cases within 30 minutes to an hour the pressures dropped 40 to 50 mms. systolic; and all the diastolics went below 100. There were no untoward cardiac signs; the only uncomfortable feeling was a numbness of the lower extremities, which symptom cleared up within two or three hours. Within an hour nearly all the previous symptoms had disappeared. Blood pressure observations taken every two hours for the first four hours, and every twelve hours after that showed a slow rise in the systolic component to about 10 to 24 mms. below the previous high levels.

Within twelve to twenty-four hours of the spinal injection, these patients were started on the *pancreatic extract*, and the pressure stabilized itself to a level lower than the admission high pressure, and the patients remained free from symptoms for from three weeks to six months.

Only one of these patients showed absolutely no reduction in pressure with the above treatment.

Another case, who was in a semi-comatose state on admission, with marked eye-ground changes and an H. P. N. of 78, showed only 8 mms. reduction in pressure, went into a coma within twenty-four hours and died.

Therefore, we concluded that in cases of extreme hypertension exhibiting prodromal signs of oncoming apoplexy and with relative grades of anemia, spinal anesthesia in combination with the pancreatic extract may be life saving, but the method is less valuable in cases of obvious cardiac failure. Marked edema, threatening coma, and dyspnea are definite contraindications to this treatment.

A typical case thus treated was:

Mrs. E. F., aged 45; admitted December 29, 1933.
Chief complaint: Dizziness, nausea, severe occipital headaches.
Physical examination: Slight cardiac hypertrophy.
Urine: Negative except for a trace of albumen.
Blood pressure: 260/130.

Spinal injection of 70 mgs. of neocaine given. (For results see Chart 5.)

The following was a typical case in which no results at all were obtained:

Mr. A. G., aged 47; C. P. A.; weight 180 lbs.
First seen June 14, 1934.
Chief complaint: Attacks of dizziness; headaches (1 yr.); dyspnea and nocturea (6 mos.).
Previous history: At age of 17 had attack of beri beri.
Present illness: Since April, 1933, dull occipital headaches, which start about 4 a. m., nocturea 5 times.

Physical examination: Fundi show scattered hemorrhagic areas, exudate on both discs; heart enlarged 13 cms. to left of midline.

Blood pressure: 240/160.

Urine: Specific gravity 1.008 to 1.010; trace of albumen; many granular casts; a few red blood cells.

Blood chemistry: Blood sugar 100.
Urea 37.
Serum protein, 6.3 per cent.
Wassermann test negative.
Pheno-sulpho-phthalein test, 35 per cent.
Electro-cardiogram, L. V. P., inversion of T, VT_2 waves, and evidence of myocardial damage. (For results see Chart 6.)

CONCLUSIONS

From the study of the records of these cases several striking and interesting facts were demonstrated, and from these certain observations are permissible:

1. Some drop in both systolic and diastolic pressure levels occurred in most of the cases. The fall in pressure averaged from 10 to 60 mms. of Hg.

2. All of the patients had a change in their subjective symptoms for the better.

3. The results obtained depended largely upon the extent of degenerative changes which the patient had undergone. The most striking results were obtained with the younger hypertensives; and with those cases who presented themselves either in the office or in the clinic because they apparently had the least amount of pathology responsible for their rise in pressure. The old chronic hypertensions showed very little change in their blood pressure reading. If there was any at all, it was only transient, but their subjective symptoms showed decided improvement.

4. In cases which did not respond at all to the treatment as outlined in this paper, pathology was so fixed that relief could not be expected with any type of treatment and the prognosis was very grave.

5. The combination of spinal anesthesia with pancreatic extract is life-saving in cases of extreme hypertension with prodromal signs and symptoms of oncoming apoplexy.

6. The pancreatic extract has a definite place in the therapeutics of the symptoms of hypertension in that it serves to detoxify the products of decomposition absorbed from the intestinal tract, and minimizes the pressor qualities of these undiscovered substances.

CHART 1

Blood Pressure of Mrs. A. G., Aged 60

Jan.	292/170—Pancreas started
Feb.	252/150
Mar.	240/140
Apr.	205/148—Pancreas stopped
May	220/152
June	280/180—Pancreas started
July	260/160
Sept.	220/140
Oct.	228/142
Nov.	220/140

CHART 2

Blood Pressure of Mrs. E. Cu., Aged 50

Dec.	200/100
Jan.	176/100
Feb.	174/100
Mar.	180/100
Apr.	180/100
June	180/100
July	180/100—Pancreas started
Oct.	160/100
Nov.	155/ 92

CHART 3

Blood Pressures of Mrs. E. Cra., Aged 58

Jan.	248/140
Feb.	248/120—Pancreas started
Mar.	214/120
Apr.	210/120
May	196/120
June	200/120
Aug.	202/120
Sep.	198/120
Oct.	200/120
Nov.	195/120

CHART 4

Blood Pressures of Mrs. C., Aged 62

Jan.	240/110
Feb.	250/100
Mar.	280/150—Pancreas started
Apr.	270/140
May	220/110
June	220/110—Pancreas stopped
July	235/115
Aug.	235/115—Pancreas started
Sep.	200/100
Oct.	190/100
Nov.	180/ 96
Dec.	185/ 92
Jan.	188/ 92
Feb.	186/ 90
Mar.	188/ 90

CHART 5

BLOOD PRESSURES OF MRS. E. F., AGED 45

Dec. 31	260/130
70 mgs. neocaine intraspinally	
Blood pressures in—	
1 hr.	172/100
2 hrs.	162/100
3 hrs.	180/105
5 hrs.	190/110
12 hrs.	190/110
Jan. 2	210/120—Pancreas started
Jan. 3	205/110
Jan. 4	190/100
Jan. 15	200/105
Jan. 20	190/ 90

CHART 6

BLOOD PRESSURES OF MRS. A. G., AGED 47

June	230/162—Started pancreas
July	225/152
Aug.	225/152
Sep.	228/158
Oct.	230/155
Nov.	230/142
Dec.	220/150

TYPE OF DIET RECOMMENDED FOR USE WITH THE PANCREATIC EXTRACT TREATMENT

Protein, 60-70; calories, 2000-2200

Breakfast

Fresh fruit.
Cereal.
Milk, ½ cup.
Heavy cream, 3 tablespoons.
Unsalted butter, 1½ tablespoons.
Egg, 1.
White bread or Rolls, 2 slices.
Sugar, 1 tablespoon.

Lunch

Meat.
Potato.
Green vegetable.
Roll or white bread, 1 slice.
Canned or fresh fruit.
Sugar, if desired.

Dinner

Rice, noodles, or macaroni.
Cheese, 2½ tablespoons.
Green vegetable.
Rolls or white bread, 2 slices.
Unsalted butter, 1½ tablespoons.
Heavy cream, 3 tablespoons.
Plain pudding.
Milk, ½ cup. Sugar, if desired.
Jam or jelly, 2 tablespoons.

Avoid:

Pickles, relishes, spices, condiments;
All salt in food;
All canned foods unless unsalted;
Soups, tea, coffee;
Salted crackers, and bought cake and cookies.

OSTEOMYELITIS OF THE SMALL BONES OF THE HANDS AND FEET FOLLOWING FROST BITE

By MICHAEL SCOTT, M.D., Resident Physician, and
ALBERT W. PIGOTT, M.D., Resident Physician and Roentgenologist,
New Jersey State Village for Epileptics, Skillman, N. J.

This case is presented because of the unusual occurrence of osteomyelitis in the small bones of the extremities following severe frostbite of these members and associated with marked gangrene of the fingers and only very small areas of gangrene on the ends of the toes of the left foot and end of the big toe on the right.

When this patient was received at our institution the diseased fingers of both hands had already been amputated. It was evident from the history sent us that the patient had severe gangrene of the fingers and although no mention is made of osteomyelitis in these members we believe that it was present as evidenced by the number of incisions and drainages that were done and the subsequent course that his frost-bitten toes followed. In this paper we are concerned mainly with the pathology in the feet since this only was under our observation.

Modern textbooks on surgery[1] that were consulted do not give osteomyelitis as a complication of frost-bite. Gross[2] in his system of surgery states: "Cold is another cause of endosteitis and there is reason to believe that many cases of necrosis of the shaft of the femur, tibia, and other long bones of the skeleton originate in this manner." He does not mention the small bones. White[3] in his text-

book on chronic traumatic osteomyelitis does not give cold as an etiological factor. A review of English printed literature discloses no cases reported of osteomyelitis associated with slight gangrene as a complication of frost-bite. Reeves and Hunt[4] report a case that somewhat resembles ours in the paucity of gangrene and the preponderance of bone changes: A soldier in the British Expeditionary Force to Russia in 1918 was employed outside as a mason. He was constantly exposed to extremes of heat and cold (having the habit of dipping his hands in hot water frequently to prevent the mortar from sticking) and often wore wet boots. This patient complained of pain in his hands and feet and blisters on the bases of his finger nails. His feet were not blistered but only blue. Examination revealed in addition to the above, clubby swelling of the ends of the fingers and toes, impaired sensation somewhat glove-like in type over the hands and feet, and normal reflexes. All other findings were negative except x-ray films which revealed increased bone formation in the terminal phalanges of the fingers and erosion of the terminal phalanges of the toes. The authors believe their case points out the effect of alternating extremes of temperature (hands) as compared with that of prolonged exposure to cold alone (feet). Baron Larrey[5] in his surgical memoirs does not mention (as far as we can find) osteomyelitis as a complication of frost-bite associated with slight gangrene.

THE HISTORY OF THE CASE

J. S., colored male, aged 52, admitted Feb. 17, 1934, from the Fitkin Memorial Hospital of Neptune, N. J.

C. C.: Epilepsy and bilateral frost-bite.

Family history: Essentially negative.

Personal history: Uses alcohol and tobacco to excess. Denies venereal infection and the use of narcotics.

Past history: Born Feb. 12, 1881. Pneumonia at 8 years of age. Malaria at 19. Otherwise essentially negative. Patient had a convulsion at the age of 36 a day after a heavy drinking bout. The occurrence of these seizures at frequent intervals resulted in his admittance to the New Jersey State Hospital for Epileptics on Jan. 4, 1929, where a diagnosis of idiopathic epilepsy, exciting cause alcoholism, was made. He was discharged on Sept. 6, 1932, greatly improved; having had only one convulsion in nineteen months. Since his discharge his general health has been excellent and he has had no complaints up to his present illness.

H. P. I.: On Dec. 30, 1933, at 6.30 a. m. this patient left for work during weather that was four degrees below zero. He insists that he had not been drinking and had taken a grain and a half of luminal the previous night. He was well clothed, his shoes were fairly mended and he wore rubbers. On his way he had a seizure and upon recovering consciousness found himself in the hospital above mentioned. An abstract of their history and treatment follows: "Patient found unconscious on sidewalk during zero weather and admitted on 12/30/33. Extremities frozen stiff. Odor of alcohol on breath.

"Jan. 10, 1934: Gangrenous fingers on right hand well up to web of fingers and infected swollen dorsum of this hand. An incision was made between the index, middle, and ring fingers extending up into the dorsum of the hand and through and through penrose rubber drains were inserted.

"Jan. 12: Gangrenous fingers of both hands. Some drainage from the left hand which is badly infected, cellulitis. Further drainage of the right hand from hypothenar eminence through web of thenar eminence. The gangrenous fingers were not touched. On the left hand all the fingers except the thumb were amputated at the metacarpo-phalangeal area.

"Jan. 27: The four fingers of the right hand are now gangrenous from their terminal ends to the middle of the proximal phalanx. The palm of the hand is infected and the incisions are open. Amputation of the four fingers was done.

"Feb. 17: Discharged to the New Jersey State Village for Epileptics. Hand healed. Some swelling remains in the feet and infection is controlled except for slight infection in the large toe of the left foot."

Physical Examination: An emaciated anemic colored male lying in bed. Pupils: Equal in size, moderately dilated and react to light and accommodation. Conjunctiva and oral mucosa pale. Dental examination made by Dr. C. W. Pullen revealed teeth in fair condition and fair oral hygiene.

Respiratory system: Excursions normal, percussion note resonant, breath sounds clear. There are a few fine râles present over left apex.

Cardio-vascular system: Heart normal in size. No murmurs heard. Pulse 72, regular in rate, rhythm, and force. No palpable vessel sclerosis. Blood pressure 102/64.

Gastro-intestinal system: No abnormalities noted.

Genito-urinary system: Negative.

Neuro-muscular and skeletal system: Triceps, biceps, and kj's are present, equal, and moderately active on both sides. The abdominal reflexes are equal and very active on both sides. Cremasteric reflex is absent. The Babinski sign was not elicited. Romberg's sign was not attempted. All the fingers of the right and left hand excepting the thumbs have been recently amputated. The incisions are covered by scabs. The thumbs are of normal size and color and show no evidence of gangrene or infection. The fingernails are very pale. There is an infected area of gangrene on the tips of all the

toes of the left foot plus much edema of the soft tissues. The right big toe is edematous and there is an area of gangrene about ¼ inch in diameter on the dorsal surface. There is impairment of voluntary motion of all the toes. Impairment of



Fig. 1. Gangrenous Tips of Toes.

sensation of all types with a feeling of numbness and electricity when tactile stimuli are applied over the surface of both feet as far as the tarsal-metatarsal area. Both feet are moderately warm to touch and the dorsalis pedis and posterior tibial arteries are palpable and pulsate well.

Laboratory findings:
Blood Wassermann: Negative.
Spinal fluid: Pressure—10 mm. mercury.
Wassermann: Negative.
Globulin: None.
Colloidal G. C.: Normal.
Sugar: .064 mg./100 mls.
Cell count: No cells.
Blood Sugar: 93 mg./100 mls.
Blood Calcium: 11.5 mg./100 mls.
R. B. C. 3,210,000; Hb. 75%; W. B. C. 9800.
Urinalysis: Amber, alk., sp. gr. 1.024; albumin negative; sugar negative, microscopic negative.

Diagnosis: Idiopathic epilepsy aggravated by alcoholism. Bilateral frost-bite of both feet.

Treatment: High caloric diet. Iron and arsenic. Alcohol dressings to infected areas and continuous heat over both feet. Calcium and ultra-violet therapy plus cod-liver oil were later added.

Progress notes: Feb. 24, 1934. X-ray report by Dr. A. W. Pigott. The right first metatarsal and phalanges show evidence of bone necrosis with some new bone formation. The distal ends of the left first, third, fourth, and fifth metatarsals and the base of the left first metatarsal show extreme bone necrosis. The phalanges of the left first, second, third, fourth and fifth toes show some necrosis and new bone formation. X-ray of chest: Both lungs are clear; heart is not enlarged.

March 7: Mantoux tuberculin test (1-1000) 2+.

March 17: X-ray. The right foot shows practically no change. The left foot shows an extension of the periosteal involvement of the third and fourth metatarsals to within three-quarter inches of the tarsal-metatarsal articulation, and of the fifth extending almost to the articulation with the tarsal bone.

April 2: Temperature fluctuating between 100 and 101. There is an abscess present on the mesial surface of the left big toe. Seen by a surgeon who advised incision and drainage of the abscess and conservative treatment. When the abscess was opened it was found to extend mainly into the sole of the foot. There were no sequestra present. A smear taken of the pus subsequently gave a culture of staphylococcus aureous.

April 4: An abscess over the lateral surface of the left heel was incised and drained.

April 13: Temperature suddenly rose to 102. Patient not oriented for time, place, or person. He is not hallucinated but is delusional and exhibits increased psycho-motor activity and confusion.

April 14: Temperature normal. Patient states that condition yesterday seems like a dream.

April 19: X-ray. The right foot shows no marked change. The left foot shows an accentuation of the previous findings with involvement of the tarsal-metatarsal region, especially of the big toe.

April 27: Patient again seen by a consultant who advised conservative therapy. R. B. C. 3,190,000; Hb. 63%; W. B. C. 6000; P. 64%; L. 34%; M. 2%.

May 25: Temperature fluctuating between 99 and 100.

X-ray: The three phalanges and metatarsal of the right big toe show marked necrosis. The left foot now shows necrosis of the first cuneiform and posterior ventral surface of the calcaneous.

June 9: X-ray. There is advancement over that seen on 5/25/34.

June 15: The left leg was amputated by a consultant at the level of the middle third. The right big toe was amputated up through its articulation with the cuneiform.

June 20: Patient comfortable. R. B. C. 2,100,000; Hb. 47%.

August 20: Except for slow healing of one side of flaps, patient made an uneventful recovery and was discharged from the hospital to his cottage with a R. B. C. of 3,980,000 and Hb. of 83%.

COMMENT

The question of whether the osteomyelitis was due to exogenous infection of the gangrenous areas with continguous infection of the bones or whether it was caused primarily by the trauma of frost-bite on the vessels supplying the bone, is open to debate. The order in which the toes were involved and the similarity in type and position of the lesions in the bones of both feet, especially in both big toes, favor a phenomenon that was caused by vascular or nerve damage or both and not mere chance infection. Because in the feet the gangrene was slight and the bone necrosis marked, one may assume that the frost-bite

affected the nutrition of the bones more adversely than that of the overlying tissues.

This man was said to have had an alcoholic breath when found on the street. It is known that alcohol taken internally causes dilatation of the cutaneous vessels and possibly a reflex constriction of deeper and larger vessels. This added to the constricting effect of cold on blood vessels might cause more marked changes in the deeper channels and thus give rise to the condition found in this case.

Epileptics are subject to vasomotor and trophic disturbances. Although this man's epilepsy was benign from the standpoint of age of onset, number of seizures, and mental deterioration, it is remotely possible that the unknown causes of his convulsive diathesis may have been a factor.

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RHEUMATOID (ATROPHIC) ARTHRITIS AND ITS TREATMENT BY GOLD SALTS

A FRENCH VIEW OF THE QUESTION

By Jacques Forestier, M.D.,
Physician to the Hospital Reine Hortense, Aix-les-Bains, France

Abstract of an address before the Atlantic County Medical Society, January 11, 1935

Dr. Forestier, who will be remembered as the originator, in conjunction with Professor J. A. Sicard, of the use of lipiodol in x-ray diagnosis, came to the United States as an envoy of the French government primarily to visit the clinics in this country intensively engaged in the study of arthritis. It was his purpose both to acquire information as to the details and progress of these investigations, and also to present the results of his own studies and those of his colleagues in the treatment of this disease.

He began his address by referring briefly to the importance of arthritis as a chronic, disabling condition having profound economic repercussions. For many years this disease has been both an annoyance and a discredit to the physician because of the confusion concerning its etiology, its nature, and all too often its diagnosis, and particularly, because the means for its treatment have been, in general, ineffectual. It has seldom, therefore, been possible for physicians to discuss it with either comfort or satisfaction. Fortunately, however, this situation is now changing, largely because of the international interchange of views among the workers in all countries who are interested in this subject.

The impetus for such an interchange began with the formation of a league for the study and control of rheumatism. Founded eight years ago in Holland, similar organizations soon formed in other countries, Dr. Forestier being asked to found that in France. The intensive work carried on in the United States, especially by Cecil, Pemberton, and many others, among whom may be mentioned Gray, of Newark, is well known.

FORMS OF CHRONIC ARTHRITIS

Perhaps the first result of the resulting interchange of ideas has been some clarification in the terminology and concepts of arthritis. All workers now agree upon two definite and distinct forms of arthritis: the *atropic* and the *hypertrophic*.

The *atrophic* form, so-called because of the obvious bone atrophy shown by x-ray, is generalized and systemic in its effects upon the patient. It may appear at any age, and from its earliest appearance is associated with definite signs of an inflammatory process in the joints as shown by redness, swelling, and pain on motion.

Hypertrophic arthritis, on the contrary, is not, clinically speaking, a generalized disease

because it involves the larger joints such as the knee and hip; and on x-ray examination, is characterized by bony hyperplasia especially on the margins and edges of joint surfaces. This disease occurs usually in the second decade of life, and affects principally the weight-bearing joints.

ETIOLOGY AND TREATMENT

The more or less general agreement on arthritis practically ends here. The etiology is still a subject of investigation and discussion. American and English investigators have studied intensively the rôle of *infection* in the production of arthritis. The subject is still an open one, however, into the ramifications of which Dr. Forestier did not enter at this time, preferring rather to outline briefly the work of his colleagues and himself in the *treatment* of arthritis.

These investigation began some six years ago, and were initiated by observations incidental to the introduction of iodized oil injections as an aid to x-ray visualation.

Thinking at that time that the pain in arthritis might be related to changes in the fat layers surrounding various joints and contributing to their formation, iodized oil was injected into these areas in an attempt to make such changes visible by x-ray. This was unsuccessful; but it was noted that many patients were relieved of pain following the injection.

IODIZED OIL

In the pursuit of these studies it developed that the site of pain in these chronic joint affections was not the *joint* per se, but the *capsules* and *ligaments* related to the joints; and that injection of these areas brought symptomatic relief, and the injection of 40 per cent iodized oil into these areas brought relief from pain in over 50 per cent of cases.

The volume of the injections was small, not more than 2 cc., given at different times until the area was well permeated by the oil. The treatments were followed by slight local reactions, swelling, redness, and tenderness, which disappeared in two or three days. The treatment is quite efficacious in securing symptomatic relief, and may be applied to any form of *hypertrophic* arthritis.

GOLD SALTS

It is the treatment of atrophic arthritis by means of the intravenous injection of gold salts which has been the subject of their recent studies and which is the main subject of Dr. Forestier's address.

While there are many who hold that atrophic arthritis is primarily an infectious process with which the streptococcus is intimately related, this view is not general and, perhaps, requires further substantiation.

Dr. Forestier was strongly impressed with it on his first visit to the United States some years ago; and he made a sincere effort on his return to France to duplicate the results obtained with vaccine treatment in this country. In this, however, he was unsuccessful. Recalling that successful chemotherapy has often antedated the discovery of the etiological agents in infectious diseases, as witnessed by the use of quinine in malaria, and the arsenicals in syphilis, he began to study the results of chemotherapy in arthritis.

The trial of gold salts was purely empiric. In Europe these have been extensively used in tuberculosis with definite results not yet admitted or appreciated in America. Both tuberculosis and arthritis are chronic infectious diseases. Why not try gold salts in arthritis?

The intensive study of gold salts in the treatment of atrophic arthritis thus began six years ago and has now reached a point where definite results can be reported. They are not to be regarded as *curing* the disease, but only as producing marked *palliative* and inhibitory effects upon the symptoms and progress of the disease; and of course, as adjuncts to many other methods of treatment well known and indicated by particular conditions in the individual patient.

One of the earliest and among the most important phases of the problem was to devise some method, both reliable and delicate, to determine and check the results of the treatment, some method free from the influence of the personal equation.

The two most suitable are the resorcinol-flocculation serum reaction of Vernes, first used in the serologic study of tuberculosis and syphilis; and the blood sedimentation reaction.

Both these reactions are reliable and deli-

cate indicators of activity of the pathologic process.

After showing slides indicating the utility of these reactions as indicators of activity, Dr. Forestier discussed the importance of the differential diagnosis between *osteophytes,* and the condition characterized by actual *calcification of the ligaments* surrounding joints, particularly those of the vertebral column, illustrating the differences between these conditions by slides. The former is harmless and generally symptomless; the latter, which he believes should be called syndesmophytosis, is progressive and, unchecked, leads to "polar spine" and disability. Fortunately, it is amenable to gold salt treatment. Early diagnosis and early treatment are all-important to the patient.

After showing numerous slides illustrative of the favorable results obtained, the method was described.

A variety of preparations have been used, allochrysin being very efficacious.

Injections are given intravenously at weekly intervals beginning with small doses (0.05 cc.). If favorably tolerated, the dose is increased to 0.1 cc. until a total of 1.5 to 2 grams of the gold salt have been given, when the treatment is stopped.

Improvement occurred in 80 per cent of cases as measured both by clinical observations, and especially by sedimentation readings. Never less than two series of treatments are given, after which the patient should return for observation and sedimentation readings at regular periods.

At times several series of treatments, or treatment two or three times a year are required to keep the patient symptom free.

Intolerance may be encountered, and must be watched for, the earliest symptom being erythema and soreness of the gums. Injections must then be stopped to avoid stomatitis and dermatitis. Intolerance may be overcome and reactions prevented by the simultaneous injection of liver extract with the gold salt.

There are definite contraindications, the most important being demonstrable hepatic or renal insufficiency, and disturbances in the bleeding or coagulation time. Simple albuminuria is not a contraindication.

The mechanism of the action of gold salts is not clear. Perhaps they influence the reticulo-endothelial system in its efforts to combat disease.

Salts of antimony have also been used with good effect in patients uninfluenced by the gold salts.

The paper was well illustrated by lantern slides, and was received with great interest.

DISCUSSION

Dr. D. W. Scanlan, Atlantic City: The discussion of Dr. Forestier's paper was opened by Dr. Scanlan who expressed his interest in the contribution made to the treatment of a chronic, long-enduring and disabling disease, one of the worst features of which was the prolonged and hopeless existence with which the patient was confronted.

He had seen some excellent results after vaccine treatment, and had also used *sulphur* intravenously with some good results. Of course other means of treatment, such as physiotherapy and salt baths, were also used. Attention to the general condition of the patient was essential. Dr. Scanlan felt that public education concerning the importance of focal infection should not be neglected. He felt, also that psychic factors, such as fatigue, were of importance. He emphasized the difficulty of distinguishing the various types of arthritis, and discussed some of the theories as to etiology.

Dr. W. C. Wescott, Atlantic City, discussed the x-ray findings and asked Dr. Forestier to outline the type of case suitable for gold salt treatment.

Dr. A. J. Davidson, Philadelphia, commented that the treatment of arthritis was mainly medical, orthopedic surgery being only an adjunct to the medical treatment.

Dr. Forestier, in closing the discussion, said that sulphur was long used by the French in the treatment of osteoarthritis, but it had several disadvantages, the possibility of causing colloidal shock, abscess formation unless suspended in oil, and so on. Pacent sulphur, and thiosulphate were of value. Diet was of relatively little importance, its restriction arising from the former confusion between arthritis and gout. Diet should be adjusted to the patient, and to maintenance of nutrition and resistance. Carbohydrate reduction seems of value but requires further study.

The atrophic cases are more suitable for gold salt treatment than the hypertrophic. Those not suitable nor favorably influenced include chronic hip joint arthritis, and also bilateral knee joint involvement, although such cases may be treated if ankylosis is absent. Old cases showing muscular atrophy do not respond although even in these remarkable results are seen at times.

THE ADRENAL SYMPATHETIC SYSTEM, AND ITS DISEASES

By George Crile, M.D., Director, Cleveland
Clinic Foundation, Cleveland, Ohio

Abstract of an address delivered before the Atlantic County Medical Society, at Atlantic City, N. J., November 9, 1934

Dr. Crile presented a summarized outline of investigations which have been carried on for some years at the Crile Clinic, the results of which are described in detail in his recently published book "Diseases Peculiar to Civilized Man". (MacMillan Co.)

The basic concept from which the paper was drawn was the division of living things, human as well as animal, into three groups:

1. The energy group, as exemplified by the tiger, leopard, and similar animals;
2. The protected group as exemplified by the crocodile, porcupine, skunk, and the like; and
3. The strategy group, which includes the anthropoids and man.

This division is based upon the reactions exhibited by the three groups in the struggle for existence, the battle for food, and the incessant warfare which characterizes life in general.

The energy group attack their prey suddenly and fight savagely, for their existence depends largely upon their ability to mobilize their power and strength and to exert it suddenly and to a tremendous degree. In the same way, animals such as the deer, the antelope, and the gazelle, in order to avoid the attacks of animals which prey upon them, must also be capable of tremendous and sudden bursts of speed, and so also of sudden and extreme mobilization and release of energy.

The protected group, on the contrary, are not so called upon. The skunk and the porcupine, for example, depend for protection, not upon their strength, but upon their specialized structural or functional peculiarities. The crocodile, armored, as it were, against attack does not have to move rapidly in order to avoid it, the same principle applying throughout the animal kingdom in general.

Man and the anthropoids, possessing neither the power nor the strength of the tiger, nor anatomical nor functional peculiarities like the protected group, must rely, therefore, upon greater or lesser degrees of ratiocination, and hence are placed in the strategy group.

Perhaps the most common emotional reaction wihch characterizes human or animal existence is fear. It would appear that, under the influence of fear, most, perhaps all, of the organs of the body are divided sharply into two groups: Those which are stimulated, and those which are inhibited. Those stimulated include the entire muscular system, the vasomotor and locomotor systems, the senses of perception, respiration, mechanism for erecting the hair, sweat glands, the thyroid, adrenal-sympathetic system, and the special senses. The digestive and procreative functions, on the other hand, are inhibited.

The significance of this stimulation and inhibition is that, as far as can be known, it results in increased efficiency for flight or battle.

It is apparent, if these concepts are logical, that the power system, so to speak, or in other words the structures responsible for the initiating of the nervous impulses which, unleashed, are translated into, or responsible for the resultant physical reactions, should show correspondingly different degrees of development in these three groups.

This power station consists of the adrenal-sympathetic nervous system, of which the thyroid, and to some extent, the other organs of internal secretion, are important, if not essential components.

Studies in comparative anatomy at the Crile Institute show this to be so. In the energy group the adrenals have a tremendous efferent nerve supply, and, together with the thyroid, are much larger than in the protected group where these organs are also smaller. Those of the strategy group—of which man is, of course, the most important representa-

tive,—occupy an intermediate position anatomically and physiologically.

From these concepts has been developed the assumption that many conditions, the etiology of which has heretofore been unknown, uncertain, or disputed, may be regarded as expressions of a pathological physiology of the adrenal-sympathetic system.

Among such conditions are that spoken of as *neurocirculatory asthenia,* of which the "Soldiers' heart" of the World War is the type example; disorders of the thyroid gland; peptic ulcer; diabetes; and combinations of kinetic diseases.

Now, if these are expressions of pathologic physiology of the adrenal sympathetic system, and especially if they represent hyperactivity in this system, then procedures tending to inhibit or decrease its activity should prove ameliorative if not curative.

Such a procedure has been devised and practiced in the Crile Clinic, namely, *adrenal denervation.*

After this condensed summary of these investigations, Dr. Crile presented, by means of slides, cases illustrative of the results of this method of treatment. These included hyperthyroidism, diabetes, and combinations of polyglandular dysfunctions.

In the discussion Dr. Merendino recalled a case of hirsutism originating in pregnancy for which Dr. Crile was unable to suggest a definite explanation. Various questions were asked by Drs. Johnson, Davidson, Harley and Roop.

In closing, Dr. Crile outlined the technical difficulties of the operation, and emphasized that it did not influence psychotic conditions in any way.

MEDICAL PRACTICE UNDER STATE MEDICINE IN THE UNITED STATES

By Francis Ashley Faught, M.D., Philadelphia, Pa.,

Chairman, Commission on Medical Economics, Philadelphia County Medical Society.

Read before the Hudson County Medical Society, November 7, 1934.

The extent of this subject makes it impossible to more than touch some of the high spots, and to repeat a note of warning to this Society as well as to all other county medical societies that we have a fight on our hands, which is not of our own seeking and which has not been forced upon us by the American public, but which is the direct result of a planned and paid propaganda by a small group supported by a number of the so-called philanthropic foundations, which have come out squarely as the advocates of State medicine. In proof of this statement, I submit the following:

Harry Moore, not a physician, published a book in 1927 advocating the principles which later developed into this active campaign.

Shortly thereafter, a few kindred spirits, none of them practicing physicians, to wit: Ray Lyman Wilbur, C. A. E. Winslow and Hugh Cumming got their heads together and decided "that something must be done". Their united activity resulted in the formation of the Committee on the Cost of Medical Care, later changed to the Committee on the Costs of Medical Care, for they soon found the title to be a misnomer, since the cost of medical care was distributed unevenly among a number of groups contributing to medical service.

The report of this committee appearing in the latter part of October, 1932, was by no means unanimous, but contained several minority reports, particularly one signed by the majority of our leading practitioners of medicine who served on this committee. Careful study of the names in these two groups will indicate clearly that there was distinct division of opinion between the two types of medical men who were *on this committee* and the division of opinion was due to their different viewpoints regarding the regimentation of medical practice. The full-time professors, health offi-

cers and sociologists, caring little for the destinies of the individual medical practitioners and having little thought for the effect of a revolution in medical practice upon the character of service rendered, naturally signed the Majority Report. The other group represented an enlightened group of medical practitioners who knew and were willing to affirm that an individualistic type of medical practice free from the interference of lay groups, or third parties, must be preserved if the highest type of medical service was to be assured in the future.

This large committee received financial support from a number of the so-called philanthropic foundations, among which the names of the Milbank, the Rosenwald, the Twentieth Century and the Pollak stand out, and among whom were divided a number of staunch advocates of State medicine, and of these a number either were, or later became, the employees of these foundations.

It was this group hardly exceeding ten that took up the refrain and have up until this time persisted in their pernicious propaganda, and have at every opportunity attempted to develop public opinion and in some instances that of the medical profession in favor of State medicine.

Out of these activities there developed certain groups more or less well-organized that have sustained and supported the propaganda for compulsory health insurance. Among these may be mentioned the Medical League for Socialized Medicine, and the American Association for Social Security. At the same time certain activities promoted and probably financed by one or more of these foundations further promoted publicity; among these stand out the names of the American Academy of Political and Social Sciences in conjunction with the Philadelphia College of Physicians, who staged a program in an auditorium at the University of Pennsylvania on Febuary 7, 1934, at which were presented ten papers, among the authors of which we find but two definitely representing organized medicine; these were—Nathan B. VanEtten and Morris Fishbein, Editor of the Journal of the American Medical Association.

Further publicity was given to this meeting by the publication, with the imprint of the American Academy of Political and Social Science, entitled, "The Medical Profession and the Public".

In the early Fall of this year appeared a program entitled "Doctors, Dollars and Disease", outwardly an activity of the National Advisory Council on Radio in Education, actually further propaganda for the promotion of State and National Health Insurance, and now within the past two weeks we have had submitted to us a model compulsory health insurance bill, supported by the association above mentioned.

Lest there be any doubt that there is a continuity of activity, actuated from some central source, let us consider the names of those who repeatedly appear in these activities. Beginning with Harry H. Moore, Ph.D., the author of the book above referred to, we find that his name appears as Director of Study of the Committee on Costs of Medical Care. In the Committee on the Costs of Medical Care we find the names of Edgar Sydenstricker, a Milbank Memorial Fund employee; Michael M. Davis, a Rosenwald Fund employee; William T. Foster, Director of Pollak Foundation. Contributing to the program of February 7, 1934, we find the names of Michael M. Davis, Thomas Parran, Jr., and William T. Foster. On the program for Doctors, Dollars and Disease, which is now appearing over the Columbia network, coast to coast, on Monday evenings from October 1st to February 25, 1935, weekly, with three exceptions, we find the names of William T. Foster, C. A. E. Winslow, Thomas Parran, Jr., Ray Lyman Wilbur, Michael M. Davis and Harry H. Moore. Certainly a consistent series of pernicious propagandists, laboring under the misapprehension that the American public wants State medicine, and that the medical profession has little to say about it.

Let us now consider for a moment the financial backing of these activities: On good authority we are told that the Milbank Fund has a capital of $10,702,093.00; The Julius Rosenwald Fund, $13,711,295.00; 20th Century, $2,460,000.00, financed by Edward Filene; and the Pollak, $3,000,000.00, approximately a total of $30,000,000.00 actively used in endeav-

oring to legislate the private practicing physician out of business.

Now a few words concerning the model Bill: This Bill contains all the unsatisfactory features of the European types of health insurance bills, including the dole. The inclusion of this feature, together with compulsory health insurance, is now recognized as unsafe and unsatisfactory in England. The Bill provides for a complete State political set-up, in which all the appointees from the health insurance commission down are appointed and subject to dismissal by the Governor. Medical representation is restricted to one physician who shall be a member of the Health Insurance Commission. The opportunity of a single physician in a commission of five, four of whom are lay persons, to control the situation is impossible.

The only provision relating to the compensation of those supplying medical service under the Bill is a provision under the heading of "local advisory committees" with a lay personnel, to fix the manner and make arrangements for remunerating general medical and dental practitioners, surgeons, etc.

Participation is compulsory for all persons employed for hire "except any person employed at other than manual labor receiving wages in excess of '250 per month'." This is $3000 per year and will absorb at least 80 per cent of all wage earners in the United States since it has been shown that before the advent of this depression the average annual income of 78 per cent of the population was $2200 or less.

Cash benefits amount to 50 per cent of the employee's full-time daily wage after the first five days and for a period of 180 days in any year. Cash benefits also extend to the dependent wife and children. Maternity benefits are provided for a duration of 12 weeks.

Medical benefits in the same income group extend after a period of six months and are available to not only the employee but his wife, all dependent children, and other dependents living in the same household.

Extent of benefits—medical services of general practitioner at home or in office, hospital and general nursing care, prenatal and maternity care at home or in hospital, surgeons' and specialists' services at office, hospital or elsewhere; the services of laboratories and clinics, and limited dental care, for a duration of 26 weeks.

Additional medical benefits include drugs, medicines, and medical and surgical supplies, nursing service outside hospital, institutional care for convalescents, medical and surgical supplies such as artificial limbs, eye-glasses, trusses, etc., dental restorative work, and the services of dental specialists.

All persons in this income group cease to be beneficiaries after a limited time following the loss of employment.

There is, in addition, a voluntary insurance provision which permits all persons whose income amounts to $5000 a year or less from any source and under 65 years of age, upon passing a health examination, to secure sickness insurance and medical benefits as provided above, upon the payment of 4½ per cent of his annual income.

It is obvious that if such a bill should pass any State legislature, that all medical practice with the exception of about 5 per cent representing persons with large incomes would be confiscated by the State, so that any of you who should refuse to accept the call to enroll and supply medical service under this Bill, would have about 5 per cent of the population on which to practice medicine.

In a recent article in the Literary Digest (July 14, 1934), Dr. Nathan B. VanEtten concisely stated why we are opposed to health insurance. Here, he said, "Health insurance abroad has failed to improve public health; it has involved the regimentation of doctors; it cannot provide reasonable compensation to medical men; because of the inevitable administrations costs, political tendencies are unavoidable"; to which we might add, that we are opposed to any such measure because it is fostered by a small non-representative group not for public good, or to improve public health, or to help the medical profession, but to relieve the industrialists of a burden which they have repudiated; vis., the payment of adequate wages, and to further increase political patronage.

Dr. Frederic E. Elliott, Chairman of the Committee on Medical Economics of the Medi-

cal Society of the State of New York, has recently said the time for resolutions is passed, and the time for action is here. I would add to this that the time for internal bickerings and dissensions and controversy regarding minor details is past. We must be united, and this union must include not only the medical profession but also the dental profession, the nursing profession, and the pharmaceutical profession, all of whom will receive their death blow should any such legislation be enacted.

We must present a united front, and to do so, we must not only seek the support of the groups that I have just mentioned, but we should increase our own strength and there are several ways in which this may be accomplished.

Among these there should be two susceptible to prompt accomplishment: 1. A counter propaganda which should emanate from every member of our profession, and should reach without delay the entire circle of patients under our care.

In order to be able to state the situation clearly to your patients, it is not necessary for you individually to study medical economics. Practically every county society today has a committee actively engaged in studying this subject; and you should have confidence in your appointees and listen to the voice of authority and not attempt to oppose your half-baked opinions against those who have devoted their time and energy in your behalf for the purpose of explaining the dangers of State medicine. You should tell them that State medicine will increase the costs of medical care, will impose a greater tax burden, will increase enormously the number of political appointees, all of whom must be paid. That this will increase the cost of Government, and that it will undoubtedly result in an inferior type of medical practice, will limit the free choice of physician, thereby destroying the most essential confidential relationship now existing between the physician and his individual patients, and will curtail medical research and the advancement of medical knowledge which is so essential to an efficient medical practice, and finally you must explain the importance and necessity of the defeat of any and all Bills directed toward the regimentation of the physician because such legislation will hurt untold thousands and will help none. By devoting a few minutes in intelligent discussion with your patients along these lines, you will materially assist those who are working night and day on various committees of your society entirely in the interests of your future efficiency and income. Whether we shall succeed in stemming this tide depends largely upon the individual physician; if we are united and persistent, I believe we shall succeed, for in union there is strength, and we must show the lawmakers of our State and Nation this Strength.

2. The enrollment of all ethical practitioners of medicine in your county medical society is essential to success, because it is only by enrolling your confreres in your society that you can reach them. An active and persistent campaign for increase in membership is urged on every county medical society, and your support of this campaign is urged.

When you receive new mmbers it should then be the duty of the older members, who are naturally more familiar with the subject, to immediately explain the grave situation that confronts organized medicine and so make them active members of your society as a committee of the whole to oppose all legislation pertaining to the socialization of medicine.

Nor should you stop here; you should personally see your local legislative representatives, both State and National, and tell them the facts regarding the effect that State medicine will undoubtedly have upon the public health through the confiscation of the practice of medicine, and show them why you believe in evolution as opposed to revolution, in medical practice; for example, ask them if they would like to have the State pick their family doctor for them.

As a county society, you should seek out the family physician of every legislator in your locality, prime him with the important facts, some of which I have mentioned above, and ask him to directly contact and discuss the subject with his patient.

I would repeat before closing that I am utterly opposed to the regimentation of medical practice, because I am absolutely certain that it will provide nothing of benefit either

to the public or to the medical profession; on the contrary, I am equally certain that the socialization of medical practice will sound the death knell of medical progress, will make efficient medical service an impossibility, and will result in an inferior type of medicine.

This statement is based upon a thorough knowledge of conditions in foreign countries where we can find no instance of a beneficient effect following the adoption of compulsory health insurance legislation; on the contrary, all evidence points to the fact that medical progress and medical efficiency has declined in all countries where some form of State medicine is in operation.

In closing, I would urge you to actively support your organization in its effort to crystallize sentiment in opposition to State medicine; by so doing you will lend active support to a campaign which should have the support of all right-thinking members of our profession.

MENTAL HEALTH AND TUBERCULOSIS

By J. Berkeley Gordon, M.D.,
Medical Director, New Jersey State Hospital at Marlboro

The association of tuberculosis with abnormalities of the psyche is by no means a newly discovered alliance. This vicious partnership between two of man's most dreaded enemies has for a number of years been the subject of careful observation. Writings of both a speculative nature and of a type based on deductive reasoning from great masses of data are fairly abundant. Whether tuberculosis tends to be caused by mental disease, and more specifically by certain well-recognized psycho-pathological entities, or whether the psychosis is the result of a toxin developed by the growth of the tubercle bacillus in the body, or whether both morbid processes are the result of some constitutional defect which causes the coincidental development of both the somatic and psychic pathology: All three of these are theses for which fairly convincing arguments may be developed.

In his classical monograph, "The Constitutional Factors in Dementia Praecox", Dr. Nolan D. C. Lewis, of Saint Elizabeth's Hospital, Washington, D. C., has analyzed the autopsy material from psychotic patients for eight years and has evaluated the effects of the associated chronic visceral disease, which is tuberculosis in 70 to 80 per cent of the cases and some other chronic affection in the majority of the remaining 20 per cent. After studying several hundred cases, it became apparent that one of the chief differences from the anatomical standpoint between the schizophrenic group and other mental disorders was located in the circulatory and lymphatic systems, and evidence was found indicating that this difference was perhaps a fundamental one, that is, part of the organization at birth and not acquired unless very early in life.

Pertaining to the so-called dementia praecox group, there are some well-established facts to which investigators are agreed:

1. The high incidence of pulmonary and other forms of tuberculosis among these cases.
2. The important part played by heredity.
3. The majority of onsets occurring early in life.
4. The presence of a strong constitutional basic factor which at times has been classed as anatomical, chemical, metabolic, glandular, etc.

As regards the circulatory system as an organic component in the dementia praecox states, Cornell in studying 241 patients found that 78 per cent of the number exhibited cyanosis of the extremities varying from a mild degree to an extreme dusky purple which was often noticeable elsewhere on the skin, particularly over the upper back, face, and lips. The presence of cyanosis was inconstant, varying from day to day. From Cornell's record, catatonic cases showed cyanosis in 90 per cent, hebephrenic in 75 per cent, paranoids in 50 per

cent, while in only 2 out of 30 cases of manic depressive insanity was this phenomenon observed. In this connection, Lewis asserts that the paranoid dementia praecox is of distinctly different constitution from the catatonic and hebephrenic types and probably should not be classed with the praecox group.

Rokitansky, of Vienna, has remarked the abnormally small hearts found in schizophrenic patients and the frequent association of small size of the circulatory system and retarded development of the sexual organs.

The tubercle bacillus thrives in the sluggish lymph stream. The schizophrenic type with its long narrow thoracic cage, asthenia, narrow costal angle, drooping shoulders, and dorsal kyphos presents a picture which is identical in its essentials with the classical "habitus phthisicus". Some writers have maintained that dementia praecox may be itself a peculiar manifestation of tuberculosis infection. Add to this primary constitutional predisposition certain life habits characteristic of mental disease types, viz: The preference for physical inactivity with deepening introversion, indoor life, idiosyncracies of diet, slow respiratory rate, etc., and we have the ideal locus for tuberculosis. How often have we all observed the early case of tuberculosis, who obeys all the rules in treating the disease, fulfilling to a high degree the well-established tripod of tuberculosis therapy: Rest, food, and fresh air, and who conscientiously takes the best possible care of himself, only to lose ground consistently and ultimately succumb to the disease; while in ironic contrast, another type, with a comparable degree of physical involvement, will persist in a high degree of strenuous activity, sometimes to the point which we call foolhardy, disobey all of the rules, keeping late hours, drinking, smoking, etc., and who despite our dire predictions of disaster conquers the disease and becomes an arrested case, when by all justice he should have been dead long ago.

Undoubtedly both an inherited and an acquired resistance to this specific germ plays a part in explaining such paradoxical results, and yet back of this there is probably operating a more fundamental factor which governs growth, vitality, disposition, life habits, and both physical and mental characteristics. This factor is probably the resultant of the complex forces exerted by our endocrine glands and operates, certainly to some extent, at least, independent of environmental influences.

Certain physical factors may be adduced to support a different view of the problem. To state that our public mental hospitals are greatly overcrowded is to repeat a truism. Indeed, admission rates to our state hospitals may serve as a sort of economic barometer rising in periods of depression and falling off somewhat during prosperity but always keeping our psychopathic hospitals filled far beyond their rated capacities. Mental hospitals thus comprise one of the major items in the state's budget. With buildings and wards housing as much as 50 per cent above their ideal number of patients, sun porches, corridors, day rooms, and recreation spaces filled with beds, it is obvious that we have a housing situation for the psychopathic patient that is far from ideal. With budgets that have been severely modified by necessary economies, the professional staff can not be expanded in proportion to the increase of population, the patients per doctor ratio rises, more patients are packed in, proper examination and classification becomes increasingly difficult; diets are curtailed, weight losses are noted in the periodic check-ups, and so the devitalizing process goes ahead.

Thus with overcrowding, improper segregation, avitaminosis, and understaffing, active tuberculosis is introduced into wards of previously uninfected patients who become ready victims. The ground is well prepared when the seeds are sown.

In a recent tuberculosis survey at the Long View Hospital for Mental Diseases in Cincinnati it was found that there has been a tuberculous death rate for the past few years of 0.7 per cent. This is more than ten times the rate for the state as a whole. Even higher rates are found in other mental hospitals. Clinical examination of 2200 patients at Long View led to the discovery of 68 cases of pulmonary tuberculosis. Due to inadequate facilities, such patients were found in half a dozen wards. This number of cases would undoubtedly be

increased by more thorough examinations, utilizing laboratory and x-ray criteria more freely. Analysis of their results seems to indicate that incidence of the disease increases with the duration of confinement in the institution. Incidence of the disease was lower among the senile and syphilitic groups and higher among the patients with so-called "constitutional psychoses". Their deductions, after eliminating all known factors, are that the tuberculosis disease develops not as the result of mental disease *per se,* or as its cause, but from the conditions of confinement and exposure to infection resulting therefrom. The doctrine of "constitutional types" underlying predisposition to mental diseases and to tuberculosis is not supported by this study.

Five years ago tuberculosis surveys were made in New Jersey State Hospitals at Greystone Park and at Trenton by Dr. Charles J. Kaufman. Of 558 patients presented for examination at Greystone Park, 184 apparently active cases of pulmonary tuberculosis were discovered. As indices to the presence of activity the most frequently used were loss of weight, fever, and tachycardia. It is to be kept in mind, however, that to a certain degree in psychotic patients these conditions may occur independently of any demonstrable organic pathology. When information concerning these points was not available, the presence of moderately coarse râles or x-ray shadows definitely indicating infiltrative changes was considered as evidence of an active lesion. A noticeable disproportion in the sex distribution of tuberculosis in this hospital is explained by the fact that the women were in general less coöperative than the men and as a result, fewer positive diagnoses were made among the females. Throughout the entire survey there was an element of uncertainty not ordinarily encountered among non-psychotic patients. The history, which is often an important factor in estimating the activity of a tuberculous lesion, is rarely of any value in these investigations. Coöperation for a satisfactory physical examination is relatively uncommon. For the same reason good x-ray plates can often not be obtained. Because of the clinician's dependence on the patient's coöperation in both the physical and Roentgenological examinations, it has been suggested that criteria be developed in studying mental patients which would make diagnosis relatively independent of coöperation. To this end the Schilling differential blood count combined with the use of tuberculin should prove valuable, especially as a means of differentiating active, potentially active, and arrested cases.

In the study of the patients in the Trenton State Hospital it was demonstrated that slightly more than 10 per cent of the population was tuberculous. The large number of cases in which a negative x-ray film was accompanied by positive sputum is striking evidence of the number of false positives to be discovered in examining the sputum of psychotic patients. This procedure presents a peculiarly difficult problem. Many patients swallow their sputum. When they do expectorate, coöperation for the collection of the specimen is often not available. Furthermore the filthy habits so common among the deteriorated patients are likely to cause frequent contamination of the sputum with non-pathogenic acid-fast bacilli. Hence it is not only difficult to obtain sputum with tubercle bacilli but the likelihood of getting many false positives is great. The habits of the patient must be noted and their possible influence on the character of the specimen must be kept in mind. Swabbing of the nasopharynx must be occasionally resorted to. The examination of the stools and gastric contents for acid-fast bacilli may be resorted to in occasional cases but these two methods are usually impracticable for wholesale examinations in crowded mental hospitals. The employment of staining methods which effectively decolorize the smegma and other acid-fast bacilli (e. g. Pappenheims Solution composed of rosolic acid, absolute alcohol, methylene blue, and glycerine) may be considered.

The detection of this disease in new patients on admission and its subsequent isolation is important both for the intelligent care of the patient and for the protection of the previously admitted inmantes. But it should also be recognized that the observation of those who have been definitely stamped as non-tuberculous on admission should be so organized that when

tuberculosis appears among them it will be disclosed soon after its inception. Periodic x-ray examinations for every patient in the institution would be the ideal method of checking up on this condition and diagnosing promptly new cases as they develop.

In estimating the frequency of the examination, use may be made of the evidence that some types of insanity are more frequently associated with tuberculosis than others. For example, the interval for the examination in the catatonic dementia praecox might be set at six or nine months, while that for the general paretic might be set at twelve or eighteen months or perhaps longer. At this point we who are entrusted with institutional finances must pause to consider with some trepidation the cost in material and professional time involved in such a diagnostic routine where from two to five thousand patients are involved in each mental hospital. Under present conditions and even for a long time to come, we know that we cannot do the job as it should be done and we would like to do it.

The New Jersey State Hospital at Marlboro is no exception to the general description of over-crowding in public mental hospitals. In the dormitories beds are placed alternately head and foot in order to minimize the transmissability of spray-borne infections. Inasmuch as the cottages are not provided with a ventilating system, it is necessary for attendants to watch constantly the matter of keeping sufficient windows open to provide fresh air without chilling patients. In good weather patients are, as far as possible, given outdoor exercise and employment.

Monthly weight charts are kept on all patients and if there is a serious loss of weight without obvious cause they are brought into the hospital building for a period of observation. The medical staff is in constant contact with the steward's department and monthly caloric analyses are made of food trays picked at random from patients as they pass through the cafeteria line.

Our policy of performing post-mortem examinations on all patients who die in the Marlboro State Hospital is probably responsible for the diagnosis of tuberculosis in a number of patients for whom the cause of death might have been assigned as some cardiac, senile, or other disase. This policy, we believe, also has a salutary effect on the diligence and diagnostic skill of the physicians, for obvious reasons.

Thus far, as the title of this paper would indicate, we have been concerned wholly with the relation of tuberculosis to the psychotic patient. We cannot close, however, without at least mentioning a related problem: Tuberculosis and our employees who take care of the mental patients. That we have a very grave responsibility in the protection of these people we cannot doubt. Our lowest grade of employees, the attendants, are proverbially underpaid. These are the people who feel the pressure of economy on our payroll. Their lives are spent in intimate contact with the disturbed, violent, and physically sick mental patients—a type of work which is strenuous and exhausting both physically and psychically. A complete physical examination including chest x-ray and blood Wassermann is given when an employee is hired. Those engaged for any type of food handling work have their stools examined for members of the typhoid-paratyphoid group. Periodic health examinations are given as seems indicated by a physician having charge of employees. Free medical and surgical attention as far as the facilities of the institution permit is considered a part of their compensation. Every effort should be made to protect employees from tubercular infection, and they should be warned when they are hired of their inevitable contact with tubercular patients both recognized and unrecognized. Our mental hospitals are fast becoming medical centers with specialized facilities for treating all disease of the soma as well as the psyche. We cannot lag in recognizing the extent of the tuberculosis problem and in making provision in buildings, personnel, and equipment to properly deal with it.

INTRAVENOUS MANGANESE IN THE TREATMENT OF PSORIASIS

PRELIMINARY REPORT OF SUCCESSFUL CASES

By JOSEPH BARR, B.S., M.D., Paterson, N. J.
Associate Dermatologist, St. Joseph's Hospital, Paterson

From the Dermatological Department of The New York Polyclinic Medical School and Hospital, Dr. Jerome Kingsbury's Service. Read before the Staff of St. Joseph's Hospital, Paterson, N. J., on October 17th, 1933.

Psoriasis is a chronic skin affection, subject to many relapses, and which may drive the patient to distraction. The disease itself does not give rise to any bodily inconvenience; but the appearance of the lesions on the exposed surfaces of the body may be a source of annoyance to his friends, and in some cases, result in loss of employment. The multiplicity of the methods of treatment is of itself indicative of the paucity of results obtained. Ointments, x-rays, etc., yield at best only temporary relief. However, within very recent years, the use of manganese in the treatment of psoriasis seems to offer the patient more than mere temporary benefits. A review of the literature reveals the fact that no reports of the use of manganese in the treatment of psoriasis have been published in this country; but reports of cases of psoriasis successfully treated with manganese have appeared in the European Medical Journals.

Van Kerkoff [1] was the first to introduce the use of colloidal manganese in the treatment of psoriasis. Upon the basis of experimental histo-chemical research, he found a decrease in the amount of oxidation taking place in the papule of psoriasis, and he believed that this was a constant factor in the causation of the disease. He further believed that the oxidational process in the epithelial cells could exist without an organic ferment. As a result, he sought a mineral activator, which would stimulate oxidation of the epithelial cells and at the same time be an acceptor of the hydrogen which is liberated.

In his search for such a mineral activator, Van Kerkoff came upon manganese, which two Frenchmen, Pauterier and Lauroumier, were using, and who maintained that colloidal manganese increased oxidation. Pauterier stated that manganese acted in the capacity of a catalytic agent during the oxidational process that took place in the cells of the epidermis.

Von Herman found that after a treatment of psoriasis with colloidal manganese, there is a considerable increase in the residual ash of the skin and concluded that manganese was deposited in the skin.

Wishing to substantiate the histo-chemical research work of Van Kerkoff, Von Dr. Rudolf M. Bohnstedt, assisted by Drs. Rudolph Schmidt and Droller, constructed his own respiratory chambers which had a capacity of 7/8 cubic centimeters. From six psoriatic patients he selected areas of skin, macroscopically free from psoriasis, and using the technic of Theirsch, he removed layers of epidermis measuring between 100 and 200 square centimeters. He placed these sections in the respiratory chambers, which were filled with Ringer's solution and determined the anerobic glycolysis. He then injected 2 cubic centimeters solution of manganese dioxide intravenously into these six psoriatic patients. After intervals of ten and thirty-five minutes, he removed similar sized sections of epidermis as before; and placed them in the chambers to determine the anerobic glycolysis. He found in five cases an increase in the production of lactic acid, more marked after the ten minutes interval than after the thirty-five minutes interval. However, in one case, there was a perceptible decrease in the production of lactic acid. Bohnstedt concluded, as did Van Kerkoff, that manganese in colloidal form, was capable of increasing oxidation in the epidermal cells in a case of psoriasis. By this action, it corrected the pathological disturbances present and promoted healing.

As is the case with any new preparation, it is essential to determine its toxicity, the best technic for its administration, and to find its optimum dosage. So was it with manganese dioxide which was the compound used then. Several investigators carried out laborious tests upon experimental animals. Professor Bec-

chold,[2] wishing to test its toxicity, injected manganese dioxide intravenously into rabbits, using .0075 gram to .005 gram per kilogram rabbit. He found a rise of temperature, varying from zero to two degrees centigrade, the average rise being one-fifth degree. As a control, he used serum and gelatin intravenously; and he noted similar rises in temperature. He found no albumin in the urine in any case of his experiments, showing that colloidal manganese is not toxic to the kidneys. He further experimented upon rats, injecting them subcutaneously and intramuscularly, using .3 to .4 gram manganese dioxide per kilogram rat. After several days, he performed necropsies upon these rats and calculated the amount of dispersion of the manganese in the tissues, as well as determining the amount of toxicity to the tissues. He found 67 per cent manganese dioxide at the site of injection, 10 per cent in the glands, and the balance dispersed in the remainder of the animal. At the site of injection, he found brown spots, but no necrosis. He concluded that most of the manganese remained at the site of injection although there was some dispersement in the remainder of the animal. Upon the basis of these animal experiments, many European dermatologists began to use colloday manganese in their various clinics, both intravenously and intramuscularly.

Bohnstedt used colloidal manganese in many cases of psoriasis, and in no case did he find any evidence of metallic poisoning, even after thirty injections were administered. When he gave colloidal manganese intravenously, he observed a rise of temperature in some cases, varying from .5 to 1 degree Centigrade, and in one case 2 degrees Centigrade. In no case did he find any albumin in the urine. His technic consisted in giving intravenous injections of manganese dioxide twice per week, beginning with 1 cubic centimeter and increasing it by one-half cubic centimeter until he gave two cubic centimeters. Usually after the eighth injection, he noticed an improvement in the case of psoriasis. If he did not notice any improvement after the twentieth injection, he ceased giving any more manganese dioxide. He usually gave a series of thirty injections. He reports treating twenty-eight patients with psoriasis of which he could observe twenty-one cases. He dismissed seventeen cases after administering seventeen injections. He treated four cases combining his injections with local therapy and chrysarobin ointment, which he noticed shortened the course of treatment. Four cases showed an improvement, five cases did not respond to colloidal manganese. In all his cases, he used ammoniated mercury 5 per cent locally.

W. Richter [3] reports treating twenty-six patients with psoriasis by means of manganese with six relapses. He believes that the relapses were due to insufficient dosage. Szego and Luka [2] report twenty-four cases of which sixteen showed complete disappearance of the lesions and eight cases showed marked improvement. They gave the injections intramuscularly practically in all cases because intravenous treatment caused rise in temperature and patient had to be hospitalized. They used local treatment in all their cases. After an interval of nine months, they saw no relapse in sixteen cases, eight showed improvement and two cases relapsed. With further treatment, the two relapsed cases cleared up.

Freund and Ravilco [2] report eighteen cases, using manganese dioxide intramuscularly. In a few cases no local treatment was used; but when combined with local treatment, they observed better and quicker results. The manganese dioxide raised the sensitivity of the skin to such a degree that ointments in very weak strength was sufficient to produce results. They used chrysarobin in .2 per cent to .5 per cent, tar 10 per cent in zinc oxide, and in severe cases of psoriasis, they used Saboroud's formula for pyrogalol with internal arsenic.

Schwartz [4] reports a case of psoriasis which was precipitated by the internal use of arsenic. The patient developed a generalized psoriatic rash. Schwartz gave him manganese dioxide intramuscularly beginning with one-half cubic centimeter and increasing it every three days by one-half cubic centimeter until he was giving the patient 4 cubic centimeters. At the fourth injection the patient experienced a severe pain at the site of injection, anorexia, fever, and weakness. He changed to a different lot number and after four more injections, the patient developed suppression of urine,

fever and weakness. These symptoms cleared up in two days. All the lesions of psoriasis, however, cleared but Schwartz would not state with any definiteness whether it would be permanent, as the interval between the last injection and period of observation was too short.

Tuttle believes that manganese dioxide injections should be combined with local therapy. He administers the manganese intravenously, beginning with one-half cubic centimeter and increasing dosage by one-half cubic centimeter every four days, until the patient is receiving one and a half cubic centimeters. This course of treatment is based on the catalytic action of manganese, the action of which is not increased with an increase of dosage. This coincides with the dictum of De Walbum [5] concerning the action of catalysts.

Schmidt [3] states that in its present form, manganese dioxide is too painful to administer intramuscularly in sufficient dosage to produce satisfactory results. With this method of treatment it is essential to combine it with local therapy. He decided that it is necessary to use a better preparation of manganese or a different combination.

After a considerable research, E. Viel has produced a preparation of manganese which may be given intravenously without any ill effects. This preparation contains a combination of manganese chloride .029 gram and calcium chloride .0095 gram in five cubic centimeters of normal saline solution. I have been using this preparation with success for the past two years.

CASE REPORTS

1. J. S., male, aged 60 years, presents himself for treatment for psoriasis March 21, 1933. He is a doorman at a club and the appearance of the lesions was a source of annoyance to the club members; and he was in fear of losing his job. His lesions, which began five years ago, covered his scalp, both ears, both palms, hands, wrists, elbows, knees, and chest. The palms were markedly infiltrated, and all the lesions were covered with dry silvery scales. The Wassermann test is negative. On March 26th, he received his first intravenous injection of manganese, and every two days thereafter until he received twelve injections. At the eighth injection, his lesions began to clear, the scales diminished and the infiltration decreased. Due to economic stress, he did not report for treatment from April 25th to June 1, 1933. He then received a further course of twelve injections. By July 19th he had received a total of twenty-four injections covering a period of four months. No local treatment was used. All his lesions have disappeared and after one year interval, no new lesions have developed.

2. G. W., aged 34 years, female, colored, domestic. She has had psoriasis for the past eight months. Her father also had psoriasis. She presented herself for treatment Nov. 29th, 1932, with generalized psoriatic lesions, varying in size from a quarter to smaller, surrounded by a precocious zone of pigmentation. The lesions on the face appear grouped circinate in appearance and have no scales. The lesions on the forearms, legs, navel, appear covered with dry white scales. Wassermann taken on Nov. 29th was negative. On Dec. 3rd, 1932, she received her first intravenous injection of manganese. She received a total of twenty-four injections, covering a period of five months; her last injection was given on May 9th, 1933. During this period she reported very irregularly, receiving three injections in December, seven in January, three in February, six in March, four in April, and one in May. After the fifteenth injection, the lesions began to clear and all the lesions had cleared at her last injection. One year later, there is no recurrence of new lesions, and only slight pigmentation remains at the site of the former lesions.

3. L. O'N., aged 29 years, female, white, nurse. She has had psoriasis for the past several years, her lesions covering the entire scalp, neck, elbows, and breasts. The scalp was markedly infiltrated and covered with an abundance of white dry shimmery scales. Four years ago, she developed secondary lues and a four plus Wassermann. She received thirteen neoarsphenamine and nine bismuth injections during the following sixteen months. The Wassermann taken then was negative and has remained negative with repeated tests. Patient was first seen April 15th, 1933. A Wassermann was taken and reported negative. A provocative test was done by first injecting .45 gram neoarsphenamine, and taking a blood Wassermann which was reported negative. On April 22, 1933, Dr. Jerome Kingsbury performed a cisternal puncture and the spinal fluid examined, and reported as follows: Cell count six cells, no globulin, Wassermann negative to all antigens in all dilutions, and colloidal gold curve oooooo. On April 23, she received her first intravenous injection of manganese. She received five injections in May, none in June, five in July. At this time her scalp showed marked improvement. She received a total of twenty-one injections. At her last injection, all her lesions had nearly cleared and a letter received at a later date states that all of her lesions have disappeared.

4. H. P., aged 52 years, male, has had psoriasis for four years. His lesions are generalized, covering his entire body and vary in size from one-eighth to one inch in diameter, and are covered with dry silvery scales. On November 1, 1932, he received his first intravenous injection of manganese. During November he received eight intravenous injections and in December he received one injection. At his last treatment, December 18th, his lesions were greatly improved; infiltration was present to a slight degree and all the scales had cleared. He did not return for any further treatment. A letter

mailed Dec. 10th was returned with no forwarding address.

5. R. R., aged 35 years, male, white, has had psoriasis for one year, and presents himself with patches on the chest, nape of neck, and scalp. On April 11th he received his first intravenous injection of manganese. Two weeks later he received his second injection. He stated that the itch present before treatment had stopped and the scales were fewer in number. He received five injections in May. At his last injection May 25th, 1933, he showed marked improvement. He reported December, 1933, for observation and noted a more marked improvement in his condition. No new lesions had appeared. He is returning for further treatment at a later date.

6. J. P., male cab driver, aged 35 years. He has had psoriasis for the past four months, with lesions of the scalp, arms, legs, chest and elbows. He was first seen July 30th, 1932, at which time he received his first intravenous injection of manganese. He has received an injection every two days until he has had a total of twenty-four injections. After he had received his eighth injection, his lesions began to clear and after the twenty-fourth injection, all his lesions had disappeared. To date, there has been no relapse. (Dr. Bocanegra Lopez's case.)

7. L. S., aged 50 years, pump inspector. He has had psoriasis for the past twenty years. In 1913 his fingernails began to crumble and break off. This condition was diagnosed as psoriasis of the nails. In 1917, he developed patches behind both ears for which he sought medical aid. Ten years after the onset of his psoriasis, he began to develop an infiltration in the crural areas, which was diagnosed as psoriasis, and in 1929 he noted the appearance of small patches on both elbows and knees. He used various lotions and ointments during all these twenty years with varying degrees of success. On October 3rd, 1933, he presented himself for treatment complaining of patches varying from one to three inches in diameter behind both ears, over lower portion of neck, at right elbow, and one patch near right knee. All his nails were involved. The Wassermann test was negative. On October 14th, 1933, he received his first injection of manganese and two more at weekly intervals. On November 11, when he received his third injection, he noted a beginning improvement in his condition. The scales had decreased and there was a diminution in the degree of infiltration. During November he received five injections and during the months of December, January and February he received twenty-two injections, making a total of thirty-two injections. The patches have practically cleared, the nails are regrowing without any trace of psoriasis. This patient is still under observation.

COMMENTS

I have given over one hundred intravenous injections of manganese without any serious reaction. The only systemic reactions noted were a slight rise in pulse rate, about ten per minute, a mild suffusion of the face, and, in some cases, a slight lightheadedness; all of which passed off in a few seconds. These reactions are not limited to manganese but may result from any colloidal preparation given intravenously. In no case was there any rise in temperature, vomiting, or any sign of toxicity following the injections. In several cases, when improvement was not rapid enough a decrease of the dosage and an increase of the interval between injections gave rise to a more marked improvement. In none of the above cases was any local treatment employed.

SUMMARY

1. The successful use of intravenous manganese in the treatment of psoriasis is discussed.

2. Ninety-five cases are reviewed and analyzed: 68 per cent total improvement, 21 per cent partial improvement, and 9.5 per cent no improvement.

3. Presentation of seven cases with five complete improvement and two partial improvement. This series is too small to justify a percentage of results obtained.

4. The histochemical and toxicological properties of manganese are discussed.

5. The technic of administration is given.

CONCLUSIONS

Particularly advantageous for therapy with manganese are the highly dispersive colloidal manganese compounds of which manganese chloride is well adopted. The minute quantity of manganese present combined with calcium chloride make it an ideal preparation for the intravenous treatment of psoriasis. Its freedom from toxicity, the ease of administration, the rapidity of disappearance of the lesions without any local therapy places manganese chloride at the head of the list of preparations used in the treatment of psoriasis. While this series is small, the results obtained are so satisfactory that continuation of this method of treatment appears justifiable.

NOTE OF GRATITUDE

I wish to extend my deepest gratitude to Dr. Boconegra Lopez for his kind assistance and enthusiasm which makes this paper possible.

THE CONTINUING PROGRAM OF THE MEDICAL SOCIETY OF NEW JERSEY

By LEROY A. WILKES, M.D.,
Executive Secretary of The Medical Society of New Jersey.

An address given before the Cape May County Medical Society at the Ocean City Yacht Club in Somers Point on May 22nd, 1935.

You have asked me to speak to you today about the Medical Society's program for the coming year. I would like to make it perfectly clear that the Medical Society's program for any given year is inseparably related to the program of the year before, and the year after, and possibly to other years. In other words, it is the *continuity* of the program of the Medical Society that is its strongest feature.

I have had the pleasure of serving with two Presidents,—President Quigley, and more recently with President Ely. During their administrations frequent communications between the President, the President-Elect, and the First and Second Vice-Presidents of the Medical Society have kept all informed of the program and the efforts made to carry it on effectively. This provision for integrating the suggestions of all of the officers of the State Society in to a program which will continue with necessary changes until its completion, is farsighted and commendable. In each year, certain phases of the program will be terminated, and others will be begun, but the work goes steadily on and shows the continuous evolutionary development, which is the basis of all sound development.

DIVISIONS OF PROGRAM

It is important to point out at this time that there are really two distinct divisions in the medical program of The Medical Society of New Jersey,—the *professional* and the *business*.

Dr. Howard Kelley has just addressed you upon one of the *professional* services,—that of diabetes. I will now discuss with you the *business methods* by which these professional services are actually made available to the individuals in the community who are in need of your professional services.

These two services in a medical program are often confused and are thought of as one; and the criticism directed against one is too often considered as a criticism against the Medical Society's entire program. I want to express my belief now that it is a mistaken idea to believe that medical practice as a profession has been under criticism. There has been, and possibly with some justification, a criticism directed at the lack of *business* methods in the distribution of our professional services to many of those in the community who are in need of them, and who do not know it or who fail for various reasons to seek advice.

I have failed to hear any responsible criticism of the *professional practice* of medicine. It seems quite agreed that the physicians in New Jersey have kept abreast of the discoveries and the outcomes of experiments that have been successfully made and which are constantly being extended to improve the quality of the professional practice of medicine.

I think the people generally appreciate all that is being done to provide them with the very best opportunities to alleviate their ills and injuries, and to prevent new injuries and the acquiring of new ills, in-so-far as experience and experiments have made it possible.

Better methods of *distributing* medical service undoubtedly can and should be worked out. We need to direct more of our efforts and experiments toward these aims.

Unfortunately the criticisms have come chiefly from persons whose own income is in a way derived from such criticism. It does not appear to come primarily from the people who themselves are suffering from illness, and who would naturally be the first to claim that the medical profession is not making a serious enough endeavor to relieve their ills.

Some criticisms have come from those in the *social* field, and in the *educational* field; but mostly from those who are employed by certain Funds and Foundations to tackle problems for which they are not professionally trained as physicians. Apparently they do not know how to interpret correctly the data they collect or to provide a better solution.

Future improvement in the distribution of medical services to the greatest number of people at the least economic cost, is not something that can be reached by statisticians and sociologists sitting around a table and gathering figures and studying them. Medical experiment and experience offer such hope as is available.

One can not get truth out of *data*, unless truth is definitely contained in the data. Unless the data is statistically sound and is characteristic of the whole, and one is assured that all of the facts are available and have been

properly handled in a statistical analysis, the true significance can not be worked out by such people. It is not a question of the sincerity of such critics, nor is the claim made that they serve no useful purpose whatever. We must endeavor to constantly improve our methods of distributing professional service to the public, and to change these if necessary to meet new conditions and needs.

ADEQUACY OF SERVICE

The claims made by some statisticians that medical services are not adequate, or at least not adequately distributed, seem to be offset by other data regarding the availability of physicians and hospital beds.

Not more than sixty per cent of the beds of the hospitals in the United States were occupied constantly, as reported in the A. M. A. hospital survey for last year. Furthermore, the United States Public Health Service reports that "never has the health of the people been as good as it has been during the recent depression". Doctors are now not nearly so busy as they were in previous years, in spite of the extra free medical provisions that are being afforded through the Emergency Relief Administration.

It is to be noted that after a five years' study of all of the available data, the members of the Committee on the Costs of Medical Care were in disagreement as to *what should be done* to improve the distribution of medical services.

One thing is certain, that the future methods to be used to distribute medical services will involve a considerable amount of *experiment* in order to determine the next step to be taken.

All of us have our own views and suggestions as to possible experimental steps. *We have a* program; but what eventually might prove to be *the best* program of medical practice and the process through which we shall best distribute most economically these services, is a matter that is subject to extended experiment and trial. The old trial and error method still holds a prominent place in all of our successful endeavors.

PAST ASPIRATIONS

In an attempt to analyze our present needs in medical practice, let us go back a bit into the history of medicine and see why the State Medical Society and its Component Societies were first organized. I believe the primary aim in the organization of the professional members into a society was to improve the physical condition of the people by improving the professional opportunities for self-improvement of the attending physician. Opportunity was provided for each physician to improve himself and thereby to improve his services to his individual patients. These are still important functions of a medical society and our post-graduate efforts in The Medical Society of New Jersey are merely a further effort along these lines.

More and more The Medical Society of New Jersey is becoming active in providing post-graduate opportunities for its members through a definitely organized program of post-graduate instruction. Much of this is now given in the hospitals of the State of New Jersey. The rest is given through didactic lectures in County Medical Society meetings.

The world changes and new opportunities appear. Some of the older opportunities are past, and since the former needs have been met, they have disappeared.

DISTRIBUTION OF MEDICAL SERVICES

Now we have, in addition to the provision of professional services, a new need to further develop our business methods in order to provide for the distribution of medical services to all the people in need thereof. This requires organization essentially,—organization and supervision, and experience in applying sound business methods. It also requires an understanding of the needs of the medical man as well as of the patient whom he serves. This is acquired only through first hand practice of medicine.

In the development of any sound plan it is well to begin with one or two factors if one is to be successful. Others can be added later on. In this way we can create a machinery to provide the necessary services within a limited scope of work suited both to individuals and to community groups. Evolution of organized effort to provide medical service for *groups* is, of course, an addition to our regular private practice with *individual* patients.

The need for this new provision for group service comes as a result of the decline in the number of private patients whose generosity in the form of bequests and donations to voluntary hospitals and to medical funds has made it possible for the physician to carry on as charity, services rendered to the indigent without pay. This voluntary service on the part of the physician began long ago, at a time when there was no other group to whom the indigent could turn. If the physician did not treat them, they were not cared for at all. Now in competition with the privately practicing physician, we have the government, and various other agencies in the state and municipalities. We have also lay organizations, founded for purposes *other than health*, who

have invaded the health field with the help of individual physicians. We have the commercial interests. We have cults and charlatans; and so it is time for the physician to realize that he is not the sole source to which the public now looks for relief, though he seems to be the sole person who is willing to contribute his efforts to the indigent without pay, and especially at night.

The President of the United States has set the pattern and the pace by which the needs of those in the community who are unable to pay for the necessary services themselves, are encouraged to look to their government for such provision. If the government now recognizes the principle that it has an obligation to provide for the indigent under all conditions, why should not the government provide payment for the necessary medical services of those chosen by the indigent to care for them in the community? It should provide for the services of organized medicine through the Medical Society.

BUSINESS ORGANIZATION NEED

In order to take advantage of this opportunity, the Medical Society must have a working organization with business-like methods by which agreements can be formed and collections made for the medical services rendered to the indigent at the reguest of the government.

If you care to use that vague term "state medicine" to designate so fair a proposition to have the government pay the medical profession to render those professional services, which only it can render, to the indigent without cost to the indigent themselves but through taxation borne by all the people, you differ in viewpoint from others who serve these people at the expense of the government.

It is no longer necessary or just that the physician himself should bear the total cost of services to the indigent. He contributes to the taxes out of which all other costs are paid. It is only fair that out of such taxes he too shall be paid for services rendered to the indigent *outside* of governmental institutions and agencies, as well as *in* them.

In any community coöperative endeavor the medical profession always stands ready to do its part on the same terms as any other community group partaking in the coöperative venture.

If the other groups in any community endeavor are contributing their services without cost, you will always find the members of the medical profession willing to contribute on the same basis. When, however, all other participants in community projects are paid for their services, there is no justification to expect the medical profession to be the sole volunteer contributor; but physicians should be paid for their services as well as any other worker in the project. This is only fair and just, and should be insisted upon. In order, however, to acquire recognition for this principle, it is necessary that the individual members of the medical profession participate in such community endeavors only as delegated representatives of their Medical Society, and not as individuals serving in the interest of another community agency without the approval of the Medical Society.

LEADERSHIP OF THE MEDICAL SOCIETY

Physicians are constantly being approached as individuals to take part in programs sponsored by other organizations—often not founded for health services, and frequently opposed by the Medical Society.

In the health service phases of such programs the success of the project often depends almost entirely upon the endeavors of a physician who delivers the actual service. While he is personally thanked for his services which form the backbone of the work, certainly no credit is given to organized medicine for his participation as its delegated representative. Frequently funds are collected from the community almost solely on the basis of the accomplishments of a coöperating volunteer physician; but often the remark is made, "The doctors are not interested in the community agencies and their work,—they are only interested in their own individual practice of medicine." I think this is most unjust, and can be obviated when each physician insists that all appeals for his help in community projects shall be made *through his medical organization*. He would then serve as an approved representative of his Medical Society with its full backing and support of the work in which he is engaged. This would redound to his professional credit, and the recognition of the project in which he works, and would obviate many of the dissentions which arise.

THE ECONOMY OF BUSINESS METHODS

All community programs must be carefully planned by those who know how to do such planning. The plans must be scheduled so that the work can be accomplished within a given time and economically. Assignment of work to the individuals participating in the project must be carefully made, so as to suit the work to the experience, training and interest of the individual. Careful records must be made in all work. These records must be subsequently studied for the purpose of improving the work and correcting mistakes which may be made.

KEEPING RECORDS

The keeping of records has never appealed very much to physicians, but more and more physicians of today are recording all of their findings carefully, so as to study their cases and avoid the same mistakes in the future; and also to discover better ways and means of accomplishing their objectives. Results can be assured only through a study of records and through personal exchange of experience such as is offered in the Medical Society.

Medical societies should also discuss the methods of *distributing* medical service. The officers of the Society should provide in each program a certain amount of time to be devoted to the discussion of the methods of distributing medical service. At present the programs in county medical societies are devoted almost wholly to professional practice. There is at this time great need for more discussion of the business of distributing these services in the local communities,—each society developing the programs suited to its own geographic section.

Our State Medical Society officers represent the County Societies and endeavor to lay out sound principles for the application of known medical services for the benefit of the public. They leave to similar committees and officers in the County Medical Societies the development of local plans consistent with the principles enunciated by the State Society. It is well, in the development of a local program, to pick out one or two things that are especially needed and to endeavor to meet these needs adequately before adding new types of endeavor. In this way, the best programs are built, part by part, before the program is expanded.

The Emergency Medical Relief Project was worked out coöperatively between the Medical Society of New Jersey and the State E. R. A. The Public Health Hour project was worked out coöperatively between the State Department of Health and The Medical Society of New Jersey. Both are fine examples of what services can be furnished through organized effort and coöperative planning to benefit the public at an economical cost.

Other services to special groups, such as preschool age examinations and health education, can be furnished by medical societies to schools, to industry and to other agencies at a cost more economical than can be provided in any other way. This will require further experiment; it will require better business organization within the Medical Society in each county, but it is entirely possible. No group in the community is better fitted to serve the public than physicians when illness is the basis of the difficulty.

In order to secure the desired flexibility and administrative control so necessary for the best development of medical services, we must retain within the medical profession both the fiscal and the administrative control, since these two are inseparable. If other agencies retain this control, we will be forced to serve as directed by them. We cannot do our best medical work under such conditions. If, however, we sell part of our services at a cost to be determined by the Medical Society, and paid directly to it, and by it distributed to its members, the Medical Society can retain the administrative control, supervision, and all the other essentials that make for the best type of work.

Such a plan will permit us to gather the necessary data both as to the experience of those working, and that of others who have previously or simultaneously done that type of work. From the study of such data we can revise and improve our program and best serve the public and ourselves. This plan is *evolutionary* and not *revolutionary*.

The Medical Society of New Jersey has based its plans on the actual experience of the members of the County Societies, and stands ready to assist and inspire every local group to evolve and extend its program along practical lines.

OSTEOPATHIC LEGISLATION

The committee substitute for the bill A1238, which was described on page 323 of the May Journal, has been passed by both the Assembly and the Senate, and signed by the Governor. This law refers to the practice of osteopathy. In its original form it granted a sweeping extension of the field of practice to osteopaths. Conferences between the representatives of The Medical Society of New Jersey and the New Jersey State Osteopathic Association led to an amicable agreement that the extended privileges should be given to those osteopaths who could prove their ability in general medicine and surgery by passing examinations of the State Board of Medical Examiners.

The practical effect of this bill will be that those osteopaths who now have the right to practice in a limited field, may acquire the rights of licensed physicans by making up their deficiencies in knowledge and undergoing the State Board's tests. It further provides that no more limited licenses to practice osteopathy will be issued.

A COUNTY MEDICAL SOCIETY BULLETIN

By Thomas McG. Brennock, M.D., Jersey City, N. J.

Read before Meeting of Secretaries and Reporters of the County Medical Societies on Apirl 30, 1935, at Atlantic City, N. J., during the Annual Meeting of The Medical Society of New Jersey

The *Bulletin of the Hudson County Medical Society* is over sixteen years of age. In its infancy, it was a pamphlet which gave the high lights of the meetings. The reason it gave only the hight spots was that the Secretary had no appropriation for an amanuensis. Therefore, the notes were in longhand, and it was impossible to get a transcript of the meetings by taking them in long-hand.

The Bulletin of the Hudson County Medical Society is published from October to May inclusive. Its activity, in fact its every function, is controlled by twelve members. These members are known as the Publication Committee. Four are elected each year for a three-year term, thereby allowing for a continuance of a majority opinion and of policy over a period of time. Shortly after the annual election in October, this committee organizes, elects its chairman and appoints its editor. After organizing, a meeting is called, and at this meeting the policy of the Bulletin is mapped out.

This policy is then presented to the Executive Committee of the Hudson County Medical Society, and from there it goes to the regular society meeting. Upon its adoption by the society as a whole, it becomes the policy under which the Bulletin is published.

The Bulletin is being published with the following outline:

1. Programs of ensuing meetings.
2. The official proceedings of the preceding meeting.
3. Current report of the executive committee meeting.
4. Abstracts of the scientific program of our society.
5. Official messages from various committee chairmen.
6. Notices of meetings of hospital staffs and of other societies.
7. Other special announcements at the discretion of the editor.
8. A limited public forum when requested.

The question of advertising in the Bulletin is rather a passive one. We feel that the Bulletin is the official organ of the society, and that it gives to the members who cannot or will not attend meetings a full view of the transactions of their society. It gives the official notices of meetings. We feel, therefore, it is a just charge upon the treasury of the society. We accept advertising from people who come to us for space, but we do not solicit it.

Our charges for space are reasonable, but by no means cheap. Our advertisers, as a rule, feel that they are getting their money's worth, and many of them have been with us for years.

The finances of the Bulletin are handled directly through the offices of the secretary of the society. The income is paid into the funds of the treasury through the secretary, and the bills incurred by the Bulletin are handled as all other bills of the society. The question as to whether there is a deficit at the end of the year, or a surplus, is a bookkeeping problem only. In the year 1933-1934 the net cost to the society was $144.50. The monthly issues consisted of from 12 to 16 pages and 550 copies were struck off at each issue, one copy going free to each of the 400 members of the society.

The Publication Committee after much forethought and deliberation decided that the Bulletin should carry a union label.

The material for publication is presented to the editor either directly or through the secretary. The editor, after checking the material for content and for correctness, takes the material to the printer, reads the proof first in galley and then in page form, and tries to have the completed copies in the hands of the secretary one week before the date of the meeting.

The editor acts in a checking capacity rather than as an editorial writer or critic. He attempts to present the material in such a way that the active members in the society are seen to move through its pages, checking only to be certain that the interests of the society are not in any way damaged.

OBITUARIES

J. HARRY TRAINOR, M.D.

J. Harry Trainor, of Newark, aged 53, collapsed after a minor operation on March 15, 1935, and died in a few hours.

Dr. Trainor was born in New York City, moved to Newark in early life, and attended Newark graded and High Schools. He studied medicine at Columbia University and graduated in 1903. He interned for one year at St. Barnabas Hospital, Newark. He practiced medicine in Newark all his life as a general practitioner, and enjoyed a large and lucrative practice, but toward later life he had confined his work to medico-legal testimony, especially Compensation Court proceedings.

Dr. Trainor leaves a widow and three grown children.

He was on the staffs of the Irvington General Hospital and the Newark Maternity Hospital.

His many friends in and out of the profession will mourn his loss. He was a kindly spoken, courteous gentleman, and a competent physician.

—H. A. Tarbell.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING APRIL, 1935

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
James A. Arbison	47	Apr. 24, 1935	975 Palisade Ave., North Bergen	Same	Carcinoma of stomach.
Thomas Barber	67	Apr. 30, 1935	Philadelphia, Pa.	Phillipsburg	
Lorenzo W. Bolan	81	Apr. 6, 1935	234 California St. Ridgewood	Same	Carcinoma of intestines. Chronic myocarditis
Leo F. Bonner	30	Apr. 22, 1935	1201 Chestnut St., Paulsboro	Same	Chronic myocarditis. Influenza.
Arthur Chapman	31	Apr. 12, 1935	Bonnie Burn San., New Providence	11 E. Hazelwood, Rahway	Pulmonary tuerculosis.
Henry B. Costill	75	Apr. 27, 1935	371 Hamilton Ave., Trenton	Same	General arterio sclerosis. Prostatic hypertrophy. Cerebral hemorrhage.
Harry A. Doherty	59	Apr. 13, 1935	2 S. Stenton Pl., Atlantic City	Same	Coronary occlusion.
James Ford	44	Apr. 26, 1935	Medical Center, Jersey City	256 Fairmount, Jersey City	Cardiac decompensation. Coronary disease. Diabetes mellitus.
Charles A. Kinch	83	Apr. 23, 1935	Presbyterian Hosp. Newark	437 N. Walnut, East Orange	Duodenal ulcer. General arterio sclerosis.
George W. King	78	Apr. 15, 1935	19 Center St., Secaucus	Same	Cerebral hemorrhage. Arterio sclerosis.
Roy F. Ogden	55	Apr. 8, 1935	Underwood Hosp., Woodbury	Clayton	Septicemia. Gangrene of index finger.
Max J. Stern	74	Apr. 25, 1935	10 N. Main Ave., Atlantic City	Same	Broncho pneumonia. Chr. bronchial asthma.
E. Blair Sutphen	58	Apr. 18, 1935	26 Olmstead Rd., Morristown	Same	Occlusion coronary artery. Arterio sclerosis of coronary artery.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

JUNE				JULY	
11	Bergen	19	Middlesex	9 Cumberland	23 Hunterdon
12	Mercer	20	Morris	16 Warren	
13	Somerset	26	Monmouth		
13	Burlington				

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held May 10, 1935, at the Ritz-Carlton Hotel, with 53 members present.

NEW MEMBERS

Dr. G. L. Infield, of Northfield, was elected to active membership.

Applications for membership were received by the Secretary from Dr. Frazier Elliott, of Hammonton, who graduated from Jefferson Medical College in 1933; Dr. Lillian Le-Kites Wallis, of Atlantic City, a graduate of Do. Homeopathic Medical College of Baltimore; and Dr. Cesare Milano, of Atlantic City, a graduate of the Royal University of Naples, Italy. These applications were referred to the Board of Censors for action.

CITY MEDICAL SOCIETY

A letter from Dr. W. H. Perry was read stating that a meeting of the Atlantic City Medical Society previously announced for April 10 would be held May 18 at 9 p. m. at the Y. M. C. A. at 1711 Arctic Avenue. The scientific program will be by Dr. W. H. Barnes on "Review of Work in the Bronchoscopic Clinic at Mercy Hospital".

MEDICAL ECONOMICS

Dr. LeRoy Wilkes, Executive Secretary of The Medical Society of New Jersey, presented a very interesting discussion of some of the economic plans which may be advanced by the physicians in the event that socialized medicine goes into effect. His address was illustrated by charts showing how these plans can be carried out.

PUBLIC HEALTH COMMITTEE

Dr. E. H. Harvey reported for the Public Health Committee. He stressed the importance of the Public Health Hour and also that every physician should instruct the parents of every new-born child just what public health measures should be carried out and when. He expressed his disappointment at the lack of coöperation from the members of the medical profession in this city and urged them to do their part in this work, stating that the sooner they did shoulder this responsibility, just that much sooner would lay clinics and welfare organizations be kept from getting patients who rightfully should be treated by physicians in their offices. Dr. Harvey said he felt that all physicians were lacking in business acumen; but that they should become more interested in the business side of their profession and should be able to pick out those patients who can afford to pay from those who cannot; and they should insist on payment by those who can afford it just the same as any other business man expects to be paid for his services.

Dr. Salasin said he did not think it would be wise to try to eliminate the lay clinics and welfare and social organizations at the present time because of the economic crisis we are facing. He did believe that the members of this society should cooperate with the Public Health Committee.

Dr. Wilkes said he believed it was up to the physicians to train the public to know that they could get much more efficient care and help from the doctor's office than from clinics where so many hundreds of patients have to be seen and rushed through, while the doctor in his office can take time and care with each patient.

INSURANCE

Mr. E. A. Wilson, who represented the local insurance agents of Atlantic County, gave an interesting talk urging the members to take their insurance requirements and problems to their local representatives. He stated that all rates must be the same in every part of the state and that the money should stay in our own county.

Dr. Crane brought up the question of discrimination on the part of large insurance companies with reference to medical attention for compensation cases.

Mr. Wilson said the only thing he could say about that was that the companies reserved the right to select their own physicians, but that he had no real connection with that part of the business.

E. R. A.

Dr. Darnall, reporting for the Medical Advisory Committee, stated that under the E. R. A. ruling, Dr. S. Goldstein, of Mays Landing was prohibited from doing E. R. A. work because of holding the position as jail physician, and asked the society to recommend him for E. R. A. work.

Dr. Rubba, of Hammonton, is also in the same position because of his appointment as a public health official.

A motion was made and passed to restore these physicians to the E. R. A. list.

Dr. Irvin stated that he felt that the amount allotted by the E. R. A. for medical services was not sufficient. Only 5 per cent of E. R. A. funds go for this work. In Atlantic City only $100 per day for six days a week is allotted for medical services, and when this is used up, as it is early each morning, the patients are referred to the Atlantic City Hospital Clinic, or told to come back the next day.

He also stated that he felt the Atlantic City Hospital was getting too large a share of E. R. A. medical funds to the detriment of the physicians who treat E. R. A. clients in and out of the hospital.

Dr. Barbash said he found that most of the E. R. A. money for medical services in Atlantic City was going to about six colored doctors, and that the other physicians were drawing only a very small percentage.

The question of the hospital collecting for prescriptions was brought up, and it was stated that this happened only when these patients had funds other than E. R. A. allotments.

GRADUATE EDUCATION

Dr. Carrington, reporting for the Post-Graduate Education Committee, stated this year's program had been very successful and that 53 physicians were enrolled. He said there was some question of discontinuing the connection with Rutgers, which he thought was not advisable as the college had been very helpful in sending out literature and giving the diplomas.

OUTING

Dr. Subin asked the wishes of the society with regard to the Annual Outing to be held at Dox Folly in June,—whether it should be held in conjunction with the members of the dental and pharmaceutical societies, or without them.

It was decided to invite them, but that the Outing should be given by the Atlantic County Medical Society alone.

A. M. A. CONVENTION

Dr. Carrington stated that there were many details to be arranged for the A. M. A. Convention, but that the membership would not be called upon until the actual time of the sessions. He requested their earnest coöperation during that time.

Dr. Sloan Stewart gave the program for the opening day on June 11th.

Dr. Read said the instructions were being carried out for the President's Ball on the 13th of June.

Dr. Conaway said the House of Delegates would have a banquet on June 11th in the Traymore Grille, the charge for which will be $5.00 per person, and requested the members to attend.

EIGHT-HOUR NURSING DAY

Dr. Scanlon reported that the Committee on the Eight-Hour Nursing Plan felt that the society should go on record as having no obection to this plan. It was moved and seconded that the Secretary so write the Secretary of the Nurses' Alumnae.

AMERICAN THERAPEUTIC SOCIETY

Dr. Charlton called attention to the joint meeting of the American Therapeutic Society with our society on June 7th at the Traymore Hotel, and urged the members to attned.

ATTENDING STATE SOCIETY MEETING

Dr. Allman, reporting for the Legislation Committee, said he had been disappointed at the lack of support given by the delegates at the recent State Society Convention. The question of the reduction of the State assessment came up, and only one Atlantic County delegate was present. He said he thought men should not be made delegates unless it was thoroughly understood that they should attend all of these meetings.

VICE-PRESIDENCY OF STATE SOCIETY

Dr. Allman stated that because Dr. Newcomb has announced his intention of resigning soon as President of the State Society because of his health, there will presumably be a vacancy in the office of Second Vice-President. He said that he has verbally been informed that, if we endorse one of our members, Dr. W. J. Carrington, for this position, that there is a good chance that he will be elected by the Trustees. He accordingly offered the following resolution:

"Whereas, the resignation of the President of The Medical Society of New Jersey is soon to be tendered to the Board of Trustees, which resignation, we presume, will create a vacancy in the Second Vice-Presidency.

"Therefore, be it resolved that the Atlantic County Medical Society hereby endorses the name of Dr. William J. Carrington and recommends him to your Board of Trustees for their consideration.

"Dr. Carrington's ability as an executive and an organizer is too well known to the entire medical profession of the State of New Jersey to enter into any detailed statements as to his qualifications.

"We of the Atlantic County Medical Society respectfully seek your favorable action upon this matter."

After considerable discussion, during which Dr. Read proposed that we support Dr. C. M. Fish for the office, the resolution endorsing Dr. Carrington was passed and the Secretary was instructed to send a copy to each Trustee.

GOLF TOURNAMENT

Dr. Conaway spoke of the Golf Tournament on June 10 at Northfield and stated that the local medical society was to be host and that it was customary to provide a trophy.

He stated that there were 18 subcommittee chairmen and that if each contributed $1.00, it would be sufficient.

BERGEN COUNTY

STAFF DEMONSTRATION WEEK, HACKENSACK HOSPITAL

Reported by Vincent Farmer, M.D., Hackensack

A most interesting Sixth Annual Demonstration Week was held at the *Hackensack Hospital,* April 15-19, 1935. Hospital Week was inaugurated in Hackensack in 1930 as a novel experiment. Its aim

was to present to the staff and to the physicians from the surrounding towns some of the more unusual cases, and to review the results in selected groups.

These demonstrations have enabled the members of the attending staff to become proficient in presenting their subject matter concisely and practically. They have also stimulated the study of timely problems in the diagnosis and treatment of disease by groups, and have been helpful in correlating the various departments of the hospital in clinical research.

The younger men on the staff have been given the opportunity to study definite problems, and to assist in the demonstration with their respective directors of services and the attending staff. This has helped to widen the interest in our Hospital Week program, and to stimulate the interest of the less active men on the staff.

An increasing attendance each year has been most gratifying, and has served as an incentive to continue this program annually. It clearly shows that more doctors interested in particular fields are being attracted to the programs devoted to their specialties.

We were happy to welcome an average of seventy-five doctors each day, many of whom came from neighboring counties.

This year the various departments arranged scientific exhibits for further demonstrations of the problems under discussion. Two of these departments took their exhibits to the State Medical Society Convention on April 30.

The sessions on each afternoon were held from 3:30 to 5:30 o'clock, an average of eight topics being presented each day. The program was as follows:

MONDAY, APRIL 15

1. *Eye, Ear, Nose and Throat*

Para-pharyngeal Abscesses, J. Decker, M.D.
Suppurative Meningitis, H. H. Vandersluis, M.D.
Diseases of the Nose and Throat in the Clinic, A. B. Speigelglass, M.D.
Plastic Surgery of the Face, William J. Greenfield, M.D.
Three Common External Diseases of the Eye, A. Liva, M.D.
Reclaiming the Blind, C. Littwin, M.D.

2. *Gynecology*

Forty-two Cesarian Sections, David Corn, M.D.
Prenatal Care to Avoid Emergency Cesarians, D. B. Hull, M.D.
Uterine Bleeding in the Fourth and Fifth Decades of Life, H. B. Wilson, M.D.

TUESDAY, APRIL 16

3. *Medicine*

Coronary Artery Thrombosis, S. B. Reich, M.D.
Artificial Pneumothorax in the Treatment of Lobar Pneumonia, H. Trossbach, M.D.
Two Cases of Complete Heart Block, F. Chester Forte, M.D., and L. W. Black, M.D.
Electrocardiogram in Problematic Cardiac Diseases, L. W. Black, M.D.
Peripheral Vascular Disease in Diabetes, G. M. Knowles, M.D.
Arthritis, H. Oren, M.D.
Obesity, C. C. Abbate, M.D.
Septicemia, R. N. Blake, M.D.

WEDNESDAY, APRIL 17

4. *Surgery*

Hernia, Strangulated, in Elderly People, W. D. Webb, M.D.
Gunshot Wounds of the Abdomen, A. I. Mader, Jr., M.D.
Neoplasms of the Kidney and Ureter, C. A. King, M.D.
Operative Treatment of Spina Bifida, George W. Finke, M.D.
Common Bile Duct Obstruction, Surgical Aspects, Vincent Farmer, M.D.
Biliary Disease, Medical Aspects, A. I. Friedman, M.D., and C. I. Van Winkle, M.D.
Treatment of Burns, S. T. Snedecor, M.D.
Avertin, G. M. Knowles, M.D.

THURSDAY, APRIL 18

5. *Fractures and Orthopedics*

Fractures of the Femur, William C. Rucker, M.D.
Compression Fractures of the Vertebrae, George W. Finke, M.D.
Oblique Fracture of the Tibia, William K. Harryman, M.D.
Bifurcation of the Femur for Osteo-Arthritis, L. Greenberg, M.D.

6. *Allergy*

Allergy. Presentation of Unusual Cases, H. M. Meyer, M.D., and J. B. Mauro, M.D.

FRIDAY, APRIL 19

7. *Pediatrics*

Placental Extract in Measles, I. M. Levitas, M.D.
Megacolon, J. Willis Demarest, M.D.
Infant Feeding Formulae, Gladys Winter, M.D.
Vitamin B. Deficiency from Polyneuritis, H. L. Mosher, M.D.
Pneumonia, Use of Blood Transfusions, David Goldberg, M.D.
Prevention of "Physiological" Weight Loss in the New Born, George M. Levitas, M.D.

8. *Obstetrics*

Cardiac Disease and Pregnancy, H. B. Wilson, M.D.
Diabetic Acidosis in Pregnancy, F. S. Hallett, M.D.
Nembutal and Paraldehyde in Labor, L. C. Nicol, M.D.
Analysis of the Fetal Mortality in 1934, C. C. Abbate, M.D.

STAFF MEETING, HACKENSACK HOSPITAL

The April 16th meeting of the *Staff Physicians of the Hackensack Hospital* was held jointly with the Board of Governors. The attendance of the physicians was poor, partly due to the fact that many of the doctors had attended the afternoon

session of the sixth annual staff demonstration week program.

The mortality for March was reviewed by Drs. Miller, Trossbach, Meyer, Knowles, and Snedecor. In particular two interesting and contrasting cases of bacterial endocarditis were presented and discussed, bringing out the variability of symptoms, and the difficulty of diagnosis and treatment.

The work of the various departments of the hospital and the contributions made by the professional staff were presented by Drs. H. B. Wilson, H. Trossbach, F. S. Hallett, D. Corn and G. M. Levitas.

Dr. Spencer T. Snedecor then gave a talk on the Relationship between the Patient, the Doctor, and the Hospital. He presented a broad view of the problem as it affected the doctors and the hospitals not only in Bergen County but throughout the country, emphasizing that the contribution of the doctors in giving free professional care and service to from 80 to 90 per cent of hospital patients and in teaching nurses in training schools, was equivalent in dollars or money value to what was contributed by the hospital, and that the doctors were the only ones who were not paid.

He quoted Dr. Van Etten on a liberal analysis of patients in a Bronx Hospital showing that 50 per cent of the patients treated without charge could either pay for such services of both hospital and doctor, or make arrangements whereby the bill could be paid.

He mentioned the burden of certain x-ray and laboratory fees to the few people who paid for such services in contrast to the actual cost, and suggested that changes be made to meet the ability of the public to pay.

Mr. W. E. Foster, treasurer, for the Board of Governors, stated that the Hackensack Hospital was today meeting all expenses in spite of the difficulties of the depression. He emphasized the great help to the hospital by the contribution of tax money through the Board of Freeholders, and expressed the hope that such support would continue in equal or even greater proportion. He mentioned the danger of relying too much on such support. Mr. Foster expressed his appreciation to the nurses, saying that he felt more pleased in paying for the nurses' services than the doctors'.

Mr. G. G. Ackerson, president of the Board of Governors, after introducing the oldest, and the three new members of the board, said that the doctors could not get along without the hospital. He emphasized that the board was always ready to consider the needs of the professional staff for equipment for better service to the public, mentioning the new anesthesia machines; and that the board might respond readily to any proposal of the Medical Board for the establishment of any worthy development, such as the proposed new tumor clinic. This would require elaborate x-ray equipment and it would be supplied in a new building.

The old building was beyond repair except at great cost, and plans for the new building were being considered again.

Mr. Ackerson spoke favorably on the insurance for hospital care that was being tried out in some of the New York hospitals.

G. M. KNOWLES, President,
Staff Physicians.

ESSEX COUNTY

Earl LeRoy Wood, Reporter

FIRST COUNCILOR DISTRICT

The Annual Joint Meeting of the Medical Societies of Essex, Union, Morris, and Warren Counties, constituting the *First Councilor District*, was held at the Academy of Medicine, Newark, Thursday evening, May 9, 1935.

Dr. Francis H. Glazebrook, Medical Director of the New York Stock Exchange, spoke on "A Plan for the Distribution of Medical Services at Reasonable Rates".

Dr. Lancelot Ely, Past President of The Medical Society of New Jersey, reviewed his recent term of office in a talk "A Year's Work with Our State Society".

Dr. Thomas K. Lewis of Camden, Chairman of the State Medical Practice Committee, spoke on "The Washington, D. C., Plan of Medical Service".

E. R. A.

The matter of eligibility for the Authorized List of the E. R. A., discussed at the Essex County Society meeting April 11th, and referred to the Council, resulted in the recommendation of the Council, that—

> "Any qualified doctor in Essex County receiving from Federal, State, County, or local governments, a salary may be approved as eligible income from these sources does not exceed the limit set by the County Advisory Committee."

This was adopted by the society without dissent, only Dr. Levy asking whether consideration was given to incomes derived from corporations, not governmental.

It solves the question of any difference between school physicians, district physicians, part-time workers, or salaried officials, etc. And it names no limit (at present $250. a month) which may be changed.

Pursuant to action of the Council, the advertising authorized ($50.57) has been spent for billboard advertising of "Diphtheria Prevention", under the Committee on Public Health. The wording was designed to mention the cause without any name or institution mentioned. These bill-boards, ten illuminated and ten unilluminated, are on display from May 1st to June 1st at the following locations, which are noted for your information, as you may choose to observe.

Illuminated

559 Central Avenue
Orange & First Streets
240 Park Avenue
351 Broad Street
Branford Place & Nickelson Street
1037 Bergen Street
Frelinghuysen Avenue & Wharton Street

Washington Avenue & Holmes Street
Bloomfield Avenue & Canal
820 South Orange Avenue

Unilluminated

180 High Street
12 Watson Avenue
94 Davenport Avenue
65 16th Avenue
902 Springfield Avenue
189 Stuyvesant Avenue
Springfield Avenue & 12th Street
Avon Avenue & 11th Street
306 Springfield Avenue
Chancellor Avenue & Rutgers Street.

The following new members were elected:

Regular

Patrick Gerard, 364 Roseville Avenue, Newark
Aaron H. Horland, 25 Van Ness Place, Newark
Eric H. Lindblade, 389 Grove Street, Upper Montclair
Henry F. Macnieski, 137 Belmont Avenue, Newark
John J. Moretti, 576 South Clinton Street, East Orange
Charles D. Ripley, 39 Lincoln Park, Newark
A. R. Saporito, 90 Midland Avenue, Arlington
Eugenio Sturchio, 178 Mt. Prospect Avenue, Newark
Henry H. Wheaton, 42 Grove Avenue, Verona

Associate

Hayes J. Burnett, 154 Bloomfield Avenue, Montclair
Albert S. Harden, Jr., 510 West Market Street, Newark
George F. Hewson. 21 Roseville Avenue, Newark
George A. Matheke, 328 Sussex Avenue, Newark
Raphael E. Remondelli. 282 South Orange Avenue, Newark.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Members of the *Gloucester County Medical Society* heard interesting addresses by County Clerk R. Edward Klaisz and Dr. Charles Behney, Associate Professor of Gynecology at the University of Pennsylvania, at their meeting at the Woodbury Country Club on May 16.

The County Clerk discussed problems of interest to physicians in connection with his office.

The meeting was the final one for the society until September.

Members present were: Drs. Dorothy Rogers, Ralph Moore, C. A. Bowersox, William Brewer, J. Harris Underwood, Duncan Campbell, E. E. Downs, H. B. Diverty, Paul M. Pegau, of Woodbury; I. W. Knight, V. I. Barrows, H. W. Wright, of Pitman; Oran A. Wood, C. C. Sheets and H. L. Sincxon, of Paulsboro; T. M. Gairdner and C. I. Ulmer, of Gibbstown; H. M. Fooder, Williamstown; Louis Ruttenberg, Mantua, and Edward Ristine and R. K. Hollinshed, of Westville. Dr. Emma Richardson, of Camden County, was a guest.

Members of the Auxiliary joined the physicians for a buffet supper at the close of the meeting.

The May *Bulletin* of the Gloucester County Medical Society has the following description of the Fifth District Meeting:

> The Officers of Gloucester County Medical Society are very proud of the way the committee put across the Meeting of the Fifth Councilor District on April 18th.
>
> The meeting will go down in history as one of the big events in South Jersey medicine.
>
> Good speakers, attentive enthusiastic listeners, and good fellowship marked the meeting.
>
> Atlantic County was represented by 19 members; Cumberland County by 18 members; Salem County by 5 members; Cape May County by 5 members; Camden County by 2 members; Monmouth County by 2 members; Mercer County by 1 member; Philadelphia County by 1 member; and Gloucester County by 28 members. Five of the Officers of the State Society were present. Burlington County was represented by 1 member.
>
> The President of the State Society was present. There were two ex-Presidents of the State Society present. The Secretary, Executive Secretary, and the Editor of the State Journal were present, together with Councilors from three of the Councilor Districts.
>
> At the tables 89 physicians were the guests of the Gloucester County Medical Society at dinner.
>
> This indeed establishes a precedent and presents a goal for us to maintain and for others to strive for.
>
> Ralph K. Hollinshed.

HUNTERDON COUNTY

A. M. Gramsch, M.D., Reporter

The *Hunterdon County Medical Society* met on April 23 with the following members present: Drs. Lane, Fulper, Boothby, Harner, English, Closson, Thomas, Coleman, Baker, Gramsch, Fuhrman, Scammell, Fitch, Hancock, Dr. Ely, President of the State Medical Society, and Mr. Hansen.

The minutes of the preceding meeting were read and approved. Dr. Slavin's request for transfer to Essex County was voted.

Dr. Harner made a report for the Public Welfare Committee. He read some of the printed form letters to be sent to the different families of the communities regarding the Public Health Hour. Dr. Lane then suggested that the doctors get busy so that it will not be taken out of their hands entirely. There was quite as discussion by the members on this subject.

Dr. Ely, President of State Medical Society, told about the progress of the society on the meeting to be held at Atlantic City. He also talked about the Doctors' Lien Bill, which is now passed. He advised the doctors get busy to fight the chiropractic and osteopathic bill. He also warned the doctor about socialized medicine.

Dr. Scammell gave a short talk on Public Welfare work. Dr. Lane made a motion that the society should send telegrams to State Senator and Assemblymen and that these telegrams come from

members of the society and also one from the society as a whole. This motion was seconded by Dr. English, and it was then voted on and passed that the telegrams were to be paid for by the society.

Dr. Boothby, Chairman of the E. R. A. Committee, reported everything was progressing nicely.

Dr. Thomas Fitch, of Plainfield, then read a paper on traumatic cerebral hemorrhage, which was supplemented with stereopticon slides.

Dr. Baker had a letter from Bucks County Medical society inviting the members of our society to hear Dr. C. C. Christie, of Washington, D. C., address them on "The Doctor and Social Insurance". This meeting is to be held May 8th, 1935, at the Court House, Court Room No. 1, Doylestown, Pa., at 1 p. m.

Dr. Baker was appointed as keyman to the Conference of Allied Medical Professions.

Dr. Harner was appointed Chairman of the Public Welfare Committee.

Meeting adjourned at 1:30 p. m. for dinner.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met at the Trenton Country Club on May 8th, President Cottone presiding.

The evening was devoted to a general discussion of the recent State Convention.

Dr. Haggerty gave a résumé of the legislative activities, while Dr. McGuire described in detail some of the finer machinations surrounding political manoeuvere.

Dr. Hutchinson reviewed the work of the Committee on E. R. A., and explained the present set-up which is now before the State Advisory Committee for consideration.

The Conference of Secretaries and Reporters was described with the several recommendations emanating therefrom.

Following a discussion relative to the Lien Law, Dr. Haggerty moved that a committee be appointed to confer with the County Clerk in relation to obtaining a special uniform blank that may be filed in the Court records.

A motion was carried that the Society go on record as opposed to the Combined Bill, 110-153 and 150.

The President appointed Drs. Sommer, West, McGuire and Adams as a committee to draw resolutions upon the death of Henry B. Costill, M.D.

The President authorized the Secretary to notify the Program Committee to arrange the June Outing, with power to select a suitable time and place.

The applications of Drs. Van M. Ellis and Evelyn M. Haines were read, and referred to the Membership Committee.

The invitation of the Pennsylvania Cancer Commission to attend a meeting in Bethlehem, Pa., May 24th was read and filed.

MIDDLESEX COUNTY

Karl Rothschild, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at "The Pines" on May 15th, under the chairmanship of the President, Dr. H. Haywood.

SCIENTIFIC SESSION

Dr. Ralph L. Barrett, Gynecologist at the Women's Hospital in New York, gave a talk on the subject of "Electrosurgical Treatment of Common Cervical Lesions". Dr. Barrett, in limiting his discussion to the benign abnormalities, was able to present in a short lecture a comprehensive picture of the historical development and modern clinical application of the various measures designed to eradicate cervical lesions. The demonstration of lantern slides with excellent color drawings of the progressive steps taken, as well as the actual application of the electrical knife, made the presentation such a valuable one.

MEETING PLACE

It was decided to accept an invitation from Dr. Molitch, of the State Home for Boys, and hold the June meeting of the Society at his institution, in conjunction with the Dental Society.

HEALTH AND ACCIDENT INSURANCE

Mr. Blankstein, the representative of the National Casualty Company of Detroit, discussed the advantages derived in this type of insurance from a company working under the direct supervision of our State Society. He further gave interesting information about the financial status of some companies who are flooding the doctors with offers of health insurance at such a ridiculously low cost that they cannot bear a serious risk. He especially stressed the fact that those companies can be sued only in their home state, thus practically avoiding any chances of being taken to account.

LEGISLATION

Dr. Nafey reported on a bill pending, having the purpose to give osteopaths additional privileges, provided they comply with strict requirements placed upon them by the State Board of Medical Examiners. Dr. Nafey feels that our rights will be fully safeguarded and that we shall have control over the legislation. It seems that here, as everywhere, this bill meets with much disapproval, as expressed by Drs. Berkow and Marks, the former believing that the chiropractors will be next to demand greater privileges, the latter emphasizing the possibility that osteopathic schools may absorb many students who now are denied entrance into medical schools.

ILLEGAL PRACTICE

Dr. Merrill reported that an itinerant drug peddler is active in the county. He goes from house to house, and after inquiring about physical disabilities, prescribes a bottle of medicine for two dollars, a box of pills for one dollar or a salve for fifty cents.

WOMAN'S AUXILIARY

A number of ladies assembled on the night of this meeting at the "Pines", and at the close of the meeting had the regular luncheon with the men. Mrs. Casselman, of Camden, addressed the meeting in a few well-chosen words. Dr. Haywood, in closing the general session, also expressed thanks to the ladies for their valuable efforts.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

EXECUTIVE COMMITTEE REPORT

The April meeting of the Executive Committee was held on Monday evening, April 8, at the Fitkin Memorial Hospital, Neptune, with the following men present: Drs. Fairbanks, Blaisdell, Altschul, Parry, Holters, Gosling, Nichols, Herrman, Fisher, Clayton and Featherston.

The correspondence pertaining to Emergency Relief matters was read and answers drafted.

The monthly E. R. A. reports (M30) submitted to the Medical Advisory Committee were reviewed.

On motion of Dr. Nichols, it was decided to apply to the E. R. A. for a clerical assistant because of the huge volume of detailed paper work which has accumulated under the medical agreement.

It was decided to hold a special meeting of all doctors participating in the medical agreement between the Monmouth County Medical Society and the Emergency Relief Administration. The purpose of this meeting is to review the agreement and instruct the men in the proper procedure for following the regulations.

It was moved, seconded, and carried that the Secretary of the Monmouth County Medical Society be made the permanent Secretary of the Medical Advisory Committee for the E. R. A. He will in turn appoint two men to serve with him for periods of two months. The Committee shall meet once a week with a representative from the E. R. A. executive staff.

The application of Dr. C. Palmer, of Keansburg, to do work for the E. R. A. was approved. The county office was instructed to place his name on the approved list.

On motion of Dr. Parry, it was decided not to have any more scientific programs until the Fall, as there are many pressing economic and State Society problems to be settled, and it would make the meetings too long.

The following resolution was presented by Dr. Nichols, and upon motion of Dr. Holters, seconded by Dr. Parry, it was voted that the Executive Committee be in favor of it:

> Resolved, That the Monmouth County Medical Society recommend that The Medical Society of New Jersey, at its forthcoming Annual Meeting, take official action to urge each component county society to raise the county dues sufficiently to provide each county society with an efficient organization for the providing of medical service and other vital needs that confront organized medicine in the present crisis. A minimum of $25 annual county dues is suggested.

Dr. Nichols also outlined a proposed plan for the Public Health Committee which will be presented at the special meeting on April 15th.

REPORT OF SPECIAL MEETING

A special meeting of the *Monmouth County Medical Society* was held in the North Solarium on the Asbury Park Boardwalk, Monday evening, April 15th. About 35 people were present, including non-members of the Medical Society and representatives of the E. R. A. Executive Staff.

For some time the Medical Society and the E. R. A. have been attempting to establish a Drug Formulary, and on motion of Dr. Fisher, seconded by Dr. Hur[illegible] it was carried to adopt the Formulary use[illegible]he Monmouth Memorial Hospital. The For[illegible]st been submitted to the Mon-mou[illegible]harmaceutical Association for pricing. Th[illegible] will provide each physician with a copy of this schedule. It was further agreed that only in special cases and with special authorization could drugs not contained in this Formulary be prescribed.

Individual problems were then presented by many of the men, and Mr. Whitney and Miss Dingley of the E. R. A. staff took part in the discussions. Following the E. R. A. session of the meeting, Dr. Charles Prout spoke on the diphtheria immunization campaign which is now in progress.

The following men are listed as specialists on the approved E. R. A. list:

Eye, Ear, Nose & Throat—
- Dr. James Fisher
- Dr. R. W. Baeseman
- Dr. W. K. Campbell
- Dr. Henry B. Dorr
- Dr. J. E. Makin
- Dr. William Matthews

X-Ray—
- Dr. William G. Herrman

Pediatrics—
- Dr. Stanley Nichols
- Dr. Lester D. Wise

Neurology—
- Dr. Clarence Trippe

Pathology—
- Dr. Carlos Pons
- Dr. S. R. DePons

Urology—
- Dr. Byron Blaisdell

HOSPITAL CONFERENCE

The following program was presented at the clinical conference of the Fitkin Memorial Hospital on Sunday morning, April 28, 1935:

Acute Pancreatitis, Dr. O. K. Parry.

Blood Dyscrasias (2 cases), Dr. Louis Albright.

Bacillary Dysentery (2 cases), Dr. Charles Prout.

Nephrectomy Following Nephrotomy, Dr. Byron Blaisdell.

Gastric Ulcer (Progress of healing as shown by x-ray series), Dr. William G. Herrman.

Fracture of Skull with Begining Meningitis, Dr. R. Pictri.

Eucephalitis (case), Dr. Samuel Hausman.

PERSONAL NOTES

Dr. Harry B. Slocum, Chief of Staff of the Monmouth Memorial Hospital, entertained the members of his staff at dinner at the Rumson Country Club

on Wednesday evening, April 10. A number of members of the Hospital Executive Staff were present in addition to approximately fifty doctors. This dinner was given in lieu of the regular monthly hospital conference.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the *Morris County Medical Society* was held at Shonghum Sanatorium (Morris County Tuberculosis Hospital), the evening of Thursday, May 16. President McMahon opened the meeting with about 40 members and guests present, aud turned the proceedings over to Dr. Harold S. Hatch, M.D., Superintendent of the Sanatorium.

Dr. George G. Ornstein, of New York, Chief of Staff of Sea View Hospital, was introduced and gave a most interesting address on the subject of "The Clinical Classification of Tuberculosis". The speaker stressed the importance of qualitative classification and of recognizing that there is acute tuberculosis as distinguished from the slow progressive type. The value of collapse therapy was emphasized in all cases presenting cavity. Dr. Ornstein detailed his subject most interestingly with elucidations by x-ray and lantern slides.

Illuminating discussion was led by Dr. John E. Runnels, Superintendent of Bonnie Burn Sanatorium at Scotch Plains (the Union County Tuberculosis Hospital), followed by Dr. D. P. Potter, Chief Resident Physician of the Hudson County Tuberculosis Hospital at Secaucus, and others who asked questions which were readily and fully answered by the speaker of the evening.

Following the scientific meeting buffet refreshments were enjoyed.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Health Center, Paterson, on Thursday, May 9th, Dr. Wright MacMillan presiding.

NEW MEMBERS

The following members having been reported on favorably were elected to membership:

Dr. J. Reuben Budd
Dr. Joseph Reiher Jehl
Dr. Eugene Thomas Kennedy
Dr. Alberico Masucci
Dr. Fulvio Patella
Dr. Raphael Rudolph Goldenberg
Dr. William Otto Wuester

Dr. Morris David Berk was elected to Associate Membership.

SCIENTIFIC

Dr. A. Sweet, Professor of Research Surgery, New York Hospital, New York City, gave a talk on "The Function of the Gall-Bladder", illustrated by lantern slides.

Dr. Sweet proposed that the gall-bladder has as its main function that of absorption. He stated that, contrary to the generally accepted idea of gall-bladder contractivity, the work he has done failed to show any evidence of gall-bladder contraction. He felt that there was definite evidence proving that the chief function of the gall-bladder was absorption.

The lecture was well received, and in the discussion the following participated: Dr. MacGuffie, Dr. Dingman and Dr. Ash.

Dr. Willard then gave a report of his participation in the Annual Convention of the State Society. He reported that several significant changes had been made in the E. R. A. rulings. The first of these was that the maximum individual bill of $250.00 in a single month had been modified. The second was that the ruling regarding one visit every ten days had been changed to one every week.

OFFICE OF COUNTY SOCIETY

Dr. Marsh then gave a report of what he considered to be of interest. He stated that the feeling was crystallizing, now that the *State Organization* was functioning smoothly, and was well organized, but that the *County Units* were far behind. In some counties the County Society had a definite office, with either a paid secretary or assistant, who could be reached by telephone or person.

Dr. Ash then asked that the possibilities along this line be investigated by the Executive Committee, and some report made.

The meeting was then adjourned.

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

The regular semi-annual meeting of the *Cape May County Medical Society* was held at the Ocean City Golf Club, Somers Point, on Wednesday, May 22nd, 1935, at 1 o'clock p. m. Thirteen members and seventeen visitors were present.

Dr. Howard Kelley, of the Presbyterian Hospital, Philadelphia, delivered an address on "Diabetes in General Practice". He went deeply into the various causes of the disease, stating that 25 per cent of cases have origin in the gall-bladder.

Dr. Kelley was voted the thanks of the society and requested to have his valuable address published in the Journal of the State Medical Society.

Dr. LeRoy A. Wilkes, Executive Secretary of the State Society, gave an address on "The Continuing Program of the State Society". This address is published on page 380 of this Journal.

THE WOMAN'S AUXILIARY

Atlantic County

Reported by Mrs. James H. Mason

April Meeting

An Executive Board meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on April 3, 1935, at the home of the President, Mrs. James North. Committee reports were called for. A discussion on the action to be taken on delinquent members resulted in dropping six members who had not paid dues for four years and who showed no interest in the Auxiliary.

The regular meeting of the Woman's Auxiliary was held on Friday, April 12, 1935, at the Traymore Hotel. Mrs. James North presided. Following the regular business, committee reports for the year were given.

The President appointed Delegates and Alternates to the State Convention April 30th and May 1st and 2nd, 1935, as follows:

Delegates

Mrs. William J. Carrington
Mrs. Stanley McGeehan
Mrs. Carl Surran
Mrs. Florence Wilson

Alternates

Mrs. Browne Holoman
Mrs. Louis Feinstein
Mrs. Anthony Merendino
Mrs. Ruffin Stamps

Mrs. North gave her report for the year's work, thanking all members for their splendid coöperation. She especially commended the Public Relations Committee which has reached at least 1200 people through their Speakers' Bureau. Eleven new members have joined the Auxiliary this year.

The Nominating Committee submitted the following ballot for the coming year:

President-Elect, Mrs. Dan Reyner
First Vice-President, Mrs. Blair Stewart
Second Vice-President, Mrs. Percy Joy
Recording Secretary, Mrs. Lawrence Wilson
Corresponding Secretary, Mrs. Manuel Malley
Treasurer, Mrs. Robert Bradley.

These were unanimously elected.

May Meeting

Reported by Mrs. Samuel L. Salasin

Mrs. Carl A. Surran presided at the meeting of the *Woman's Auxiliary to the Atlantic County Medical Society*, held on May 10, with thirty-five members present.

The meeting opened with an unusual program. Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey, addressed the meeting on the doctor's part in public health for diphtheria immunization, vaccination against smallpox, regular periodic health examinations, and baby health clinics. He was followed by Dr. Samuel L. Salasin, who urged the women to coöperate in this public health hour.

Mr. Kenneth Lynch, an expert armor maker connected with the Atlantic City Horse Show, gave an address on "Jousting During the Age of Chivalry". Mr. Lynch comes from a long line of armorers, and is in Atlantic City for the purpose of preparing armor in connection with the revival of jousting as an organized sport. At the coming horse show, jousting will be introduced for the first time in the United States.

The new officers of the Auxiliary are:

President, Mrs. Carl A. Surran.
President-Elect, Mrs. Dan Reyner.
Treasurer, Mrs. Robert Bradley.
Corresponding Secretary, Mrs. E. Mally.
Recording Secretary, Mrs. Lawrence Wilson.
Membership, Mrs. Baxter Timberlake, Chairman; Mrs. Eugene Dalton.
Telephone, Mrs. Raymond Williams.
Program, Mrs. Ruffian Stamps, Mrs. Stanley McGeehan.
Public Relations, Mrs. E. G. Shreves.
Entertainment: Social, Mrs. Hilton Read; Literary, Mrs. Arthur Von Deilen; Music, Mrs. Clarence Whims; Athletics, Mrs. Brown Holomon.
Publicity, Mrs. Winn, Mrs. Salasin, Mrs. Edward Guion.
Widows and Orphans, Mrs. Harry Subin.
Welfare, Mrs. Charles Sinkinson.
Hygeia, Mrs. Anthony Merindino, Mrs. James Mason.

Bergen County

Reported by Mrs. Charles Littwin

The April meeting was held on Tuesday evening, the 9th, at the Hackensack Hospital. Plans for a reciprocity meeting were discussed, and a meeting is promised for the early Fall. The annual luncheon is to be held May 14th at the Hackensack Golf Club.

Fifty dollars has been given to a needy doctor's family from the Philanthropic Fund and a donation is to be sent to the Fund to purchase sound effects for the motion picture outfit at Bergen Pines

The winners of the essay contest on Vaccination to Promote Public Health were announced. Ten dollars was given Frances Durkin, of Holy Angels Academy, and five dollars to Virginia Clark, of the Tenafly Junior High.

Dr. C. Whitman, Hackensack dentist, entertained with card tricks and slight-of-hand demonstrations.

Gloucester County

Reported by Mrs. Henry P. Diverty

March Meeting

The *Woman's Auxiliary to the Gloucester County Medical Society* held its regular meeting Thursday evening, March 21st, at 9 o'clock at the Hotel Pitman. The President, Mrs. J. Harris Underwood, presided. After the business meeting a buffet supper was served to the ladies and doctors.

The *Woman's Auxiliary to the Gloucester County Medical Society* held its Spring meeting Thursday evening, April 18th, at 2 p. m. at the home of Mrs.

Elwood Downs, Delaware and Childs streets, Woodbury.

Mrs. Chester I. Ulmer, of Gibbstown, and Mrs. I. W. Knight, of Pitman, were a committee on arrangements.

A sextette of ladies from Swedesboro furnished the musical program, with Mrs. Hill as accompanist. Mrs. Hill also played several piano solos, which varied the program. The guests were very enthusiastic with applause.

Miss Clarette Sehon gave a talk in the interest of the Vineland Training School for Feeble-minded Children, which the ladies appreciate deeply. Miss Sehon is a very able speaker.

Members and guests were present from Glassboro, Pitman, Gibbstown, Swedesboro, Paulsboro, Westville, Wenonah and Woodbury. After the program refreshments were served.

May Meeting

The *Woman's Auxiliary to the Gloucester County Medical Society* held its May meeting at the Woodbury Country Club. The following officers were elected: Mrs. J. Harris Underwood, Woodbury, President; Mrs. Don Weems, Wenonah, President-Elect; Mrs. Fuller Sherman, Woodbury, Vice-President; Mrs. Paul Pegau, Woodbury, Secretary; and Mrs. David R. Brewer, Woodbury, Treasurer.

Members of the Auxiliary joined the physicians for a buffet supper at the close of the meeting.

Hudson County

Reported by Caroline Culver

April Meeting

The monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on the second Monday in April at the Y. W. C. A., on Fairmount Avenue, the President, Mrs. Frank P. Nicholson in the chair.

The minutes of the previous meeting were read and approved.

Plans were completed for the card party to be held the next day at the home of Mrs. L. F. Harter in Teaneck.

In place of the Spring luncheon, a supper dance and card party is being arranged to take place at the Swiss Chalet, which is to be in conjunction with the men in a real get-together and become-acquainted party.

The election of officers followed when the entire ticket presented by the Chairman was unanimously elected. President, Mrs. A. E. Jaffin; Vice-Presidents, Mrs. Charles B. Kelley, Mrs. Arthur Largay, Mrs. Andrew Ruoff; Treasurer, Mrs. Harry Perlberg; Recording Secretary, Mrs. Edward G. Waters. The Corresponding Secretary is appointed by the President.

The following names were presented as Delegates and Alternates to the New Jersey State Medical Convention, to be held at Haddon Hall in Atlantic City April 30th and May 1st and 2nd: Delegates, Mrs. Frank P. Nicholson, Mrs. Charles B. Kelley, Mrs. William Freile, Mrs. A. E. Jaffin, Mrs. Peter Maras and Mrs. E. J. Chapman; Alternates, Mrs. L. L. Perkel, Mrs. Andrew Ruoff, Mrs. Robert Stockfisch, Mrs. John Connell, Mrs. S. Herbert Culver and Mrs. George M. Culver.

It was voted to hold the May meeting the second Monday instead of the regular first Monday.

As a part of the afternoon program Mrs. John Nevin entertained the members by giving a review of "The Dog of Flanders". This was received with much enthusiasm.

Mrs. S. A. Reich and an able committee served tea and a social hour followed, when all had the opportunity to meet the newly elected officers and to thank Mrs. Nevin for her kindness.

May Meeting

The monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday, May 13th, 1935, at the Y. W. C. A.

A luncheon was held before the meeting, to which Mrs. Casselman, of Camden; Mrs. H. Roy Van Ness, of Newark, and Mrs. Don Epler, also of Newark, were invited as guests and speakers. We deeply regretted that, on account of illness, Mrs. Casselman and Mrs. Van Ness were unable to attend. Covers were laid for ten and a social hour was enjoyed by the others.

Later the meeting was called to order by Mrs. Frank P. Nicholson, the retiring President.

Reports of the recent state convention were given by the delegates, and it was a source of much gratification to the members to learn that the Hudson County Auxiliary has four members among the state officers, namely, Mrs. William Freile, and Mrs. George M. Culver as Vice-Presidents, Mrs. Edward G. Waters as a director, and Mrs. Frank P. Nicholson as state chairman of press and publicity.

Five new members were welcomed and plans made for the Spring program, in which one of the events will be a supper-dance at the Swiss Chalet, in Rochelle Park, on Saturday, June 8th.

During the afternoon Mrs. Warren J. Duckett, an active member of the Auxiliary, who has been the senior councilor for the Jersey City Junior Woman's Club for the past three years, was asked to report on the many honors that came to this club at the recent Federation convention in Atlantic City.

Dr. B. S. Pollak was the speaker for the afternoon and he gave the highlights in his thirty years' experience fighting tuberculosis, which was both interesting and instructive.

Tea and a social hour followed, with Mrs. A. E. Jaffin, our newly elected President, as Chairman of Hostesses.

Mercer County

Reported by Mrs. Alton S. Fell

Under the auspices of the *Woman's Auxiliary to the Mercer County Medical Society* and the education department of *The Contemporary Club*, a Public Relations Tea was held March 13th at The Con-

temporary, West State Street, Trenton. Members of the Medical Auxiliary, The Contemporary Club, and Parent Teacher Associations throughout the city were in attendance.

Dr. LeRoy Wilkes, Secretary of the State Medical Society, introduced Dr. Lancelot Ely, President of the same organization, and main speaker of the afternoon, who spoke upon "The Family Doctor".

Dr. Florence Childs spoke on the subject "The Work of the Welfare Division of the Health Department".

Mrs. A. J. Casselman, of Camden, President of the Woman's Auxiliary of the State Medical Society, also addressed the assemblage.

Sponsored by Mrs. Irwin P. Davenport and Mrs. James R. Harman, a health playlet, "Putting Up the Sign", was presented.

Mrs. Hans Hansen, soprano, gave a group of musical selections both preceding and following the program. Tea was served by members of the Hostess Committee composed of Mrs. C. C. Chianese, Mrs. Paul R. Finegan, Mrs. Edward K. Hawke, Mrs. William C. Ivins and Mrs. J. E. Wyckoff.

Mrs. Alton S. Fell, Chairman of the medical group, and Mrs. Kurt B. Lagerson, Educational Department Chairman, were in charge of the arrangements.

On March 18th members of the Woman's Auxiliary held a luncheon meeting at the McKinley Hospital Nurses' Residence. The President, Mrs. Alton S. Fell, presided.

On Friday afternoon, March 29th, a card party was held at the Nurses' Residence of Mercer Hospital on Bellevue Avenue. During the afternoon tea was served.

Mrs. William J. Harman, of West State Street, Trenton, has invited the members of the Auxiliary to an organ recital to be held at her home on Wednesday afternoon, April 24th, from 3 until 5 o'clock. The program will include organ selections by Edward A. Mueller and vocal solos by Mrs. Raymond Phillips and Mrs. Charles H. Waters.

At the conclusion of the meeting, tea will be served.

On April the 24th the members of the *Woman's Auxiliary to the Mercer County Medical Society* were the guests of Mrs. William J. Harman, of West State Street, Trenton, at an organ recital given at her home. Edwin Mueller was the guest organist and Mrs. Raymond Phillips and Mrs. Charles H. Waters rendered vocal selections. Following the concert, tea was served. The color scheme was yellow and white.

Monmouth County

Reported by Mrs. W. K. Campbell

The quarterly meeting of the *Woman's Auxiliary to the Monmouth County Medical Society* was held Friday, March 29, 1935, at the Berkeley-Carteret Hotel, in Asbury Park. A luncheon preceded the meeting. The President, Mrs. W. K. Campbell, presided.

The members voted to double their subscription to the Convention's Entertainment Fund.

A resolution from the Vineland Woman's Club was read and endorsed. The members also voted to contribute to the fund for the continuance of the Research Department of the training school at Vineland.

The Auxiliary voted to help make the exhibit of Arts and Hobbies at the State Convention at Atlantic City a success.

Mrs. Lewis S. Thompson, President of the Monmouth County Organization for Social Service, has appointed Mrs. Stanley H. Nichols to represent the Auxiliary on the County Welfare Board.

A fitting tribute was paid to the memory of the late Mrs. W. J. Donovan, wife of Dr. Donovan, of Brielle, one of the Auxiliary's most esteemed and beloved members.

The Auxiliary was addressed by Dr. Charles Prout, of Asbury Park, on the importance of vaccinating against smallpox. He also strongly recommended immunization against diphtheria, especially for the pre-school child.

Dr. H. C. Graves, of Marlboro, gave a splendid address on psycho-therapy.

The next meeting of the Auxiliary will be held at Shrewsbury on Friday, May 31, 1935.

Those attending the meeting from Long Branch were: Mrs. W. K. Campbell, Mrs. H. B. Slocum, Mrs. S. H. Nichols, Mrs. H. Kazmann, Mrs. Joseph Binder; from Asbury Park: Mrs. William Herrman, Mrs. James Fisher, Mrs. O. K. Parry, Mrs. O. R. Holters, Mrs. Stanley Brown, Mrs. W. Von Oehsen; from Freehold: Mrs. Harry Ingling, Mrs. H. H. Friedman, Mrs. Harvey Brown, Miss Reynolds; from Belmar: Mrs. R. E. Watkins.

Somerset County

Reported by Mrs. Charles F. Halsted

The Annual Meeting of the *Woman's Auxiliary to the Somerset County Medical Society* was held April 11, 1935, at the home of Mrs. Lancelot Ely. Nine members were present, also several guests. After the reading of the minutes of the February meeting and the Treasurer's report, the Nominating Committee presented the following names for office for the ensuing year:

For President, Mrs. A. Longstreet Stillwell.

For President-Elect, Mrs. W. J. Albrecht.

For Vice-President, Mrs. R. K. Adams.

For Recording Secretary, Mrs. Charles F. Halsted.

For Treasurer, Mrs. Benjamin Borow.

Mrs. Edgar T. Flint and Mrs. Runkle F. Hegeman were elected Directors for two and three years respectively.

A musical program followed by Mrs. Benjamin Borow who sang several original compositions of her father, Mr. Aronson, of New York, who accompanied her at the piano, and entertained most beautifully with classical and popular numbers.

Mrs. Ely, assisted by her daughters, the Misses Barbara and Evelyn, served delightful refreshments.

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VIEW OF THE GROUNDS



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THE JOURNAL

OF

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THE JOURNAL
OF
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Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

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EDITORIALS

The Presidency

The Medical Society of New Jersey wisely follows the custom of electing a President who has gained an extensive experience in the offices of Second and First Vice-President, and President-Elect. The inaugural address of your President at the last Annual Meeting contained the statement that the major activity of the Presidency in the immediate future would be that of Medical Legislation, in which he has been actively engaged during his three years of intensive service in the preparatory grades of office in the State Society. Your President then expressed his willingness and expectation to resign his office in order that it could be filled by some one who was not charged with a specific duty in addition to the general work of the presidency, which is both extensive and intensive.

AIDES TO THE PRESIDENT

Since the Annual Meeting it has come to the knowledge of the President that considerable thought had been given to the development of a system which will provide assistance for the President in many of his duties of a routine and time-consuming nature, such as the visitation of county societies and the attendance at local conferences. The system will also provide the President-Elect and the two Vice-Presidents with broader responsibilities which will be of great value as they advance in office.

Informal conversations with the other officers of the Society have disclosed their willingness to assume many of the executive and advisory duties which have undergone such an extensive development during the last half decade that they should be shared by a staff of congenial assistants. It would seem that now is the proper time to institute such a system of aides and personal representatives of the President, in which the President-Elect and the Vice-Presidents should be the leading members.

Your President will therefore continue in office with the expectation that those in line for advancement shall at once assume a share in the responsibilities which are associated with the presidential office, especially those for establishing and maintaining personal contacts between the leaders of the State Society and the members of the county units.

Marcus W. Newcomb.

Major Problems, New and Old

A number of major problems will demand the attention and study of The Medical Society of New Jersey and of the County Societies during the coming year. Some activities have already been started but their administration will need continued attention. Others have been discussed and the bases for their acceptance have been laid, but their establishment must await a broader education of both the physicians and the people.

Among the more evident projects of the medical year are the following:

1. The continuation and expansion of the Public Health Hour in our offices.
2. A better understanding between Hospital Managers and the Medical Staffs.
3. The employment, if possible, of paid secretaries for county societies, on either part time or full time.
4. Amendments to the Workmen's Compensation Act to allow a freer choice of physician.
5. A Uniform Medical Practice Act.
6. Encouragement of physicians to take part in civic and community affairs as representatives of the County Medical Society.

Your President had hoped to initiate the establishment of a permanent home in Trenton for the office of the Society and its records, and to start a State medical library. While this ideal may be impossible at present because of the economic depression, it is hoped that succeeding Presidents will keep this project in mind when times become normal.

Now that the Social Security Bill in Congress has passed, there will undoubtedly be many things to consider in connection with this law which are of vital concern to the medical profession.

The work which the Woman's Auxiliary is doing is worthy of our hearty encouragement. The coöperation and support of every county society and auxiliary will enable the medical profession to extend the distribution of medical services along the standard lines which have been planned and practiced by our predecessors.

Marcus W. Newcomb.

The Inter-Relations of Medical Societies

The Annual Meeting of the American Medical Association held in Atlantic City June 10-14 was humbling in its greatness but inspiring in its details.

THE COUNTY MEDICAL SOCIETY

The *County Medical Society* is unparalleled in affording its members the opportunities for learning the details of the practice of medicine and the development of mutual relations of the people and the medical profession. The practice of medicine, to a far greater extent than that of any other profession, requires the personal contact of a highly trained expert with a patient, be he ever so humble.

The County Medical Society also affords the opportunity for the great medical leaders to ascertain the adaptability of their advanced discoveries and methods to the individual sick under every conceivable condition of facilities and economics.

The members also profit by the contacts and friendships with great leaders who esteem it a personal privilege to instruct practicing physicians in the application of the latest results in the field of research and experimentation in the great hospitals and laboratories. The County Medical Society is essential to the modern practice of medicine.

THE STATE MEDICAL SOCIETY

The *State Medical Society* is the County Society on a large scale. Its activities are those of its Component County Societies, and its participants are the County Society members who exchange views regarding the larger problems of local medical practice. Here the representatives of the smaller county societies

are accorded an equal recognition and standing with those of the larger cities. The State Society is the County Society glorified with the opportunity to assemble an array of talent and exhibits which are available piecemeal to the County Societies.

THE AMERICAN MEDICAL ASSOCIATION

The *American Medical Association* is an extension of the greater features of the Medical Societies of the states and the counties. Here the representatives of a thousand County Societies and forty-eight State Societies bring together the best features of their local organizations; and every physician feels entirely at home in the exhibit halls and the scientific meetings. No individual doctor can possibly study its 300 scientific exhibits or listen to the 1000 speakers listed on the programs, or gather samples and circulars from the 250 exhibitors of medical wares. No room is large enough for assembling the 8000 physicians who came to it from all parts of the United States. But every doctor can find a full measure of satisfaction in those features which make a personal appeal to his preferences and his desires.

The Annual Meeting of the American Medical Association is the apotheosis of the highest ideals of the State Societies and the County Societies. This is the testimony of every one of the nine hundred sixty-seven New Jersey physicians,—31 per cent of the membership of the State Society,—who registered their attendance at the Annual Meeting of the American Medical Association during the second week of June.

Organizing for Medical Service

A medical organization develops best when it is an adaptation to local needs. It may be instituted as an extensive system, thought out within a cloister and planned for mass action. Such a system may be compared with a forest of grown-up trees which are transplanted from a nursery into a soil which is often rocky and dry, and poorly adapted to their growth.

A far better system is that which may be compared with seedlings which adapt themselves to the soil in which they are planted. They send out their sturdy roots between the crevices of rocks and deep into soil where they can find nourishment, and can eventually develop into a forest covering a mountain side on which transplanted trees wither or are borne down by local storms and floods.

Denmark affords a striking example of a medical system developed by the physicians themselves in contrast with that of the German system imposed on the profession which had little to say in its planning and growth. In Denmark, every physician is a health officer reporting to a government which accepts the pronouncements of the medical practitioners without question.

New Jersey has the makings of a system like that of Denmark. Its medical profession has already planted the seeds here and there which have shown a vitality and capacity for steady growth. The *Emergency Relief Administration,* managed by the medical societies of the State and counties, is an example admired throughout the nation. The *Public Health Hour* originated by the medical profession requires only the coöperation and nurture of the lay health organizations to develop a State-wide efficiency. The method of *Medical Legislation* originating with the medical profession, and strengthened by the coöperation of the allied professions of Dentistry, Pharmacy, and Nursing, has demonstrated an efficiency which compels popular respect. These are examples of the growth of ideas and systems planted and nourished through the organized efforts of practicing physicians.

New Jersey no longer needs to rely on outside assistance in planting and nourishing its system of medical service in fields which await tilling by its own practitioners.

Seasonal Activities

Although the projects of the medical societies of the State and counties of New Jersey go on continuously and progressively, yet the curve of their activities rises sharply beginning with the Fall months, and culminates in a sharp peak in the Annual Meeting in the late Spring.

There is a natural reason for this characteristic curve. The Annual Meeting marks the end of the terms of many officers and committeemen, when many of the leaders are advanced to higher positions and new groupings are made. But New Jersey wisely follows the custom of overlapping terms, thus assuring a continuity of plans and their execution.

The Journals from April to July classify and summarize the activities of The Medical Society of New Jersey during the past year. The Journal of April contains forty-four pages of reports of the officers and committees; and that of May summarizes the events of the Annual Meeting. The month of June was one of editoiral activity in preparing the official minutes of the House of Delegates and the Annual Meeting of the Woman's Auxiliary, whose results are set forth in the "Transactions" of eighty-eight pages, which are published as a supplement to this July Journal, making this issue by far the largest one of the year. The amount of space devoted to the Annual Reports and the Transactions in the Journals of May and July reflects the unusual scope and extent of the year's activities compared with those of previous years, as is indicated in the following table:

Table of pages of The Journal devoted to the reports of officers and the Transactions during the past six years.

	Reports of Officers	Transactions
1930	0	56
1931	0	86
1932	0	76
1933	0	70
1934	40	56
1935	44	88

The seasonal activity of the Medical Societies of New Jersey is more apparent than real. Summer activities go on with undiminished zeal, for the leaders are busy with developing the plans for the coming year. New projects are under development, former activities are being extended, and assignments to new duties are under consideration. The leaders will be active all through the summer, and the results of their planning will be evident in the Fall when all phases of the work will be resumed with renewed vigor.

Good-Fellowship at Medical Meetings

The annual meetings of The Medical Society of New Jersey and the American Medical Association, both held in Atlantic City a month apart, afforded examples of that good-fellowship which is essential for success in any organization. The lectures and demonstrations, the exhibits, and the business meetings, atracted those who were especially interested in the business and economic phases of the delivery of medical service. The physicians who took part in the State meeting numbered 465, while 967 physicians of New Jersey were registered at the Annual Meeting of the American Medical Association.

Fraternalism was the most striking feature of both annual meetings, for it appealed to everybody. Meeting former associates and making new friends were the underlying features which made attendance at the meetings a delight, and furnished the incentive for a continued interest in the essential work of the societies.

Good-fellowship is the hormone which activates the members in the performance of their duties. It reveals to them the finer qualities of their associates, and inspires them with a zeal for coöperation in projects of mutual interest. The informal conversations of friends, and the social dinners and sports are of equal importance with the formal sessions.

Medical Waves and Tides

There is a type of health promotor, usually a lay worker, who rides the crest of every wave of medical progress until it breaks upon the shore and recedes, leaving him upon a sandbar of disappointed aspirations until a new wave again raises him on its alluring crest. Waves are spectacular to those on shore, but dangerous and alarming to those who encounter them.

True medical progress is a rising tide, slow, quiet, and imperceptible, yet affording the Ship of Progress a safe entrance into port where it may discharge its cargo of achievement for the relief of human need. Even the flats left bare by its recession teem with living forms of life where fishermen gather food for the sustenance of life.

The high tide of Medical Progress in New Jersey was reached in its Annual Meeting on April thirtieth and May first and second, when the captains and crews of the fleet of medical voyagers gathered together to tell of their experiences and discoveries, and refit themselves for another year of adventure and achievement.

The Medical Profession sails by means of its reliable chart and compass, and its knowledge of its ship and of the deep mysteries of the human body and mind. It knows the sailing channels, and the location of hidden rocks on which amateur voyagers soon find themselves stranded and dishonored.

The accredited members of the healing craft are pilots and life savers who are always ready to instruct inexperienced adventurers and to direct them to safety in the time of storm, which is sure to follow every period of calm sailing. The people and the thoughtful leaders of amateur health groups are now realizing their dependence on the Medical Profession for their sure guidance along the safe channels of the way to health.

The Attractiveness of the Hospital

A picture shown in the booth of the American Hospital Association at the meeting of the American Medical Association is a benediction to every patient in a modern hospital. Its central figure is a mother reclining on her pillow and smiling on her young daughter who sits on her father's knee at the bedside, while in the background the nurse stands serene and confident, a radiant ministering angel.

The whole atmosphere of the painting is entirely true to life. The hospital is a temple of hope and confidence, and a shrine of returning strength and happiness. The patient is guarded from unpleasant sights and sounds, while anesthetics and the skillful touch of the doctor and nurse transform expected ordeals into pleasant memories. A serene calm and inexpressible relief takes the place of the tense apprehension with which the patient enters the hospital.

This is a true picture of the experience of the great majority of patients in every standard hospital. It is commonplace to the doctor and the nurse, but inspiring to those who need the services of the institution, for it is prophecy of expected health and happiness.

Spider Bites

Arachnidism, or poisoning by a spider bite, is practically unknown in New Jersey; and yet it may be encountered at any time, for the insect that does the biting is present in the State.

On June fourth a man brought to the office of the State Society a milk bottle containing a large black spider, and asked if it might not be of a poisonous variety. The specimen was sent to the State Entomologist in New Brunswick, who identified it as the *Latrodatus mactans,* or "Black Widow" because the female eats her mate. The specimen had been collected in the low grass in a garden in a back yard of

the city of Trenton, and the finder had correctly surmised its identity from descriptions which he had read in the daily papers.

The specimen was a large fat spider, with an inch and a half spread of legs, and a jet black, shiny abdomen,—an unusual color for a spider. The identifying marks was a small spot of brilliant orange on the under side of its abdomen. Besides its color, the spot had a characteristic constriction making it shaped like an hour glass.

The spider prefers damp localities, and many of its bites have been acquired in outdoor toilets, where the spider spins its web under the seat. A suggestion for prevention is to brush away any spider web that is found under the seat of an outdoor toilet.

The immediate sensation following a bite is that of a severe bee sting. The characteristic symptom comes on within a very few hours and consists of painful cramps in the legs, and later in the abdominal muscles, producing symptoms which may be mistaken for an acute peritoneal infection, such as that from a ruptured duodenal ulcer.

While the spider is common in the Southern States, no cases of their bites have been reported in New Jersey, yet their possibility is to be considered in cases of persistent, painful contractions of the abdominal muscles. The mark or history of a bite is also suggestive.

Several articles on arachnidism have recently appeared in medical journals, an excellent one being that in the Journal of the American Medical Association of May 18, 1935, page 1790. The treatment suggested in the Journal consists of morphine and sedatives for the relief of the pain and the muscular contractions. A specific recommendation is the intravenous injection of a 20 c.c. ampule of a ten per cent solution of magnesium sulphate, which has the specific property of relieving the muscular contractions. Although a severe bite may be dangerous to life, the cases reported in the A. M. A. Journal recovered within twenty-four hours by treatment with magnesium sulphate.

Read Your Journals

Your Journal has an immediate value for its current *news;* and a permanent value for *reference.*

The news contained in your Journal is much more than items that satisfy the curiosity. The Journal carries announcements of vital interest to *you.* Every issue is a *bulletin* on particular projects in which *you* are personally interested for self-protection as well as for the impersonal object of promoting scientific medicine. Every issue is therefore a personal letter to you informing you of the development of new methods of medical service, and of your own influence and responsibility in directing the new movements.

The Medical Society of New Jersey follows six methods informing you and inspiring you to action:

1. The Journal.
2. Special bulletins.
3. Mimeographed instructions.
4. Personal letters and appeals.
5. Telephone calls.
6. Personal visits.

The Journal is the fundamental means by which you learn what your colleagues are doing, and the methods adopted to secure *your* coöperation with your medical brethren. If you read your Journal, you may save the Society the expense of the other five means of communicating with you.

Events in the field of the distribution of medical services are developing with bewildering speed. The national Social Security Act will force you to do some intensive thinking for your peace of mind and possibly your professional existence.

Read your Journal for its *news* of the newer developments in medical objectives and administration. Then preserve your Journal for continuous *reference.*

Buy the box prepared by the State Society for keeping your Journals where you can always find them. (See adv., page xi.)

ORIGINAL ARTICLES

ADDRESS OF WELCOME

By Marcus W. Newcomb, M.D., Brown's Mills, N. J.,
PRESIDENT OF THE MEDICAL SOCIETY OF NEW JERSEY

Delivered in Atlantic City, N. J., at the opening General Session of the American Medical Association, in its 88th year, June 11, 1935.

Mr. President of the American Medical Association, Mr. President of the Canadian Medical Association, Delegates, Honored Guests, and Friends: It is indeed a pleasure as well as a privilege and a great honor, as President of The Medical Society of New Jersey, to welcome you to Atlantic City, the Playground of the World, in the Garden State of the United States. We are especially happy to have with us at this convention our good neighbors, the Canadian Medical Association. May your visits be frequent.

The American Medical Association is the largest medical society in the world, and I have the honor to represent the oldest State Medical Society in the United States. Last month we held our 169th annual convention in this city. The Medical Society of New Jersey was formed at the home of a Mr. Duff in New Brunswick, New Jersey, on July 23, 1766. The first item of business recorded was the consideration of fee lists. It is interesting to note that, even at that early date, our medical forefathers were discussing economics. They applied to the State Legislature for a charter, which was granted. On May 5, 1767, the Society adopted a rule that a medical student should study and work under a preceptor for four years, one of which could be spent in a Medical School. For this, the apprentice should pay one hundred pounds. At the time of organization, a constitution was adopted. Article seven provided for the organization of "Inferior" Societies to meet every three months and report their proceedings to the State Society. There were no meetings held between the years 1775-1781 due to the Revolution. I could cite many more interesting facts concerning our State Society, which you can find in the *Journal of The Medical Society of New Jersey* for May, 1935, in the address of our retiring President, Dr. Lancelot Ely.

Mr. President, if I may, I should like to make a few suggestions through you to the House of Delegates. I have had the privilege to represent Burlington County in the State Legislature for the past eight years, this year being Majority Leader in the Assembly. First, let me say that I am not a politician, but a doctor. In my opinion, the Medical Profession is facing critical times due to the depression, unemployment, state medicine, health insurance, and other social service measures. There has been a lot of legislation enacted in the different states which has been very detrimental to our profession and the cause of public health. Why has this legislation been enacted by laymen? Because the doctors have not taken sufficient interest in public affairs, and in the kind of men and women that are sent to the legislatures. I warn you, ladies and gentlemen, that, if the doctors and those in allied professions do not wake up and interest themselves in electing men and women of high standards who are honest and interested in Public Health and everything else that is for the uplifting, betterment, and health of our people, we shall have more unwise laws put on our statute books by laymen. We should have more medical men in the legislatures. The time has long since passed when the doctor can fold his arms and say, "My duty is to treat the sick. Let the other fellow look after civic affairs." We, as medical men, must take an interest in all civic and community affairs, not only as citizens, but as representatives of the Medical Society. We will be in a dual capacity. We should lead in all public health work in our County and State. This is our plain duty.

The function of the County Societies, the State Societies and the American Medical Association is to formulate policies and pass them on to the physicians, and to work for the in-

terests of the physicians in all legislation affecting the profession and the public health. We look to the American Medical Association for constructive leadership. In my opinion, every State Society should keep in close touch with all legislation, and should have a legislative agent at every session of the Legislature, so as to keep its officers and the Welfare Committee informed of all bills which are of interest to the medical profession. I am informed that there are some vicious bills in Congress at present, one of which is aimed at the Pure Food and Drug Act. I hope that our Association is combating any weakening of the enforcement provisions of the present law.

It is through such meetings as these, with an exchange of ideas, experiences of different members and frank discussions of medical and surgical services and their distribution that we increase our knowledge of diagnosis and treatment of disease and their application in improving the health of the people.

I trust that your stay here will be very pleasant and instructive and that you will take home with you renewed strength and enthusiasm for your chosen work. Again I welcome you.

THE INTERNE, THE NEW DEAL, AND THE WARD PATIENT

By Richard D. Anderson, M.D., Burlington, N. J.

Read before the Staff Meeting of the Burlington County Hospital, Mount Holly, N. J., October 26, 1934

This paper is a plea for instructing the hospital interne in habits of uniform courtesy and consideration toward all patients of every class. His attitude toward the patients will determine the reputation of the hospital, and his own success. Although the attitude of patients may change, that of the interne and attending physicians must remain one of kindliness.

THE DEMOCRACY OF SICKNESS

The interne has a more intimate and perhaps trying contact with the ward patient than any other person connected with the hospital, except the nurse in charge of his ward. It is in this laboratory that he, as a physician, has his first contact with the sick human being. In reality the young doctor has begun to practice medicine, albeit he may not realize it, and his work is here done under more ideal conditions than he will ever again find. Whether or not he senses the fact, he has assumed a position more serious and more responsible than any other young man of his average age in any line of human endeavor. Four years before, when entering the study of medicine, his professor of anatomy had probably delivered to his class an eloquent short oration pleading respect for the bodies of his less fortunate brethren, from whose dissection he was permitted to obtain anatomical knowledge which he could in no other wise attain. Then, throughout his subsequent training in the medical school, one professor after another had stressed the importance of his developing a kindly attitude toward the sick. He was urged to regard his patient not as a case, but rather as one of the same God-made men of flesh and blood as he who professes to alleviate suffering.

Yet I fear too often we see in the wards of our hospitals the highly and efficiently trained young men who have the minimal characteristics of humility, tolerance, respect, gentility, and sympathy toward the unfortunate victims of disease. No matter what his creed or color, the ward patient, after all, is a living, feeling, and, so often, highly sensitive man who, by the very reason of his own physical and financial misfortune, has much to offer the interne—I dare say more, in many instances, than the young doctor may have to give.

The hospitals of the United States are the most modern and up-to-date institutions of

their kind in all the world. Architecturally, they represent practically the last word in construction, and they are equipped with every facility for caring for the sick and the maimed. They are the interne's workshops and should be the patient's haven of help and humane treatment. Their vast network of social service departments is unexcelled in efficiency by those of any other country. Their directorates are composed of the highest types of individuals to be found in the community. Nurses and even orderlies are chosen with a great deal of care. Internes are selected more or less upon their scholastic standing.

Throughout our land there come to the wards of these institutions a vast variety of patients. They may differ in race and religion, yet all are sick people seeking one objective, succor of the medical profession. While, by name, hospitals may be designated as Presbyterian or Methodist, St. Agnes, or Jewish, yet never is an applicant declined admission because of his denomination, his faith, his nationality, nor his political allegiance. For, in the words of the great John Chalmers DaCosta, almost twenty years ago:

"There is no such thing as a Friendly cancer, a Baptist strangulated hernia, an aristocratic carbuncle, nor a Republican fracture."*

Again, this mighty teacher and surgeon, comparing the hospitals in their care of the poor in the last of the Nineteenth Century with those of 1915, says:

"Even thirty years ago (written in 1915) the poor in general were suspicious and distrustful of hospitals. When a poor man was taken to a hospital he went reluctantly, and with grim forebodings of the worst. He believed he was going to exposure among strangers, to surgical and medical experiments, to clinics, to neglect, probably to cruelty, and to the traditional 'black bottle', and the dissecting room should his disease prove interesting or his presence annoying.

"How changed things are today (1915). The poor man knows that he will find in the hospital food, shelter, rest, kindly care, sympathetic attention, and the most humane and scientific treatment. He goes there as a matter of course."

Let us look at the record now in 1934 and see whether, with all the improved hospital facilities for "food, shelter, rest and scientific treatment", we have progressed equally in matters of "kindly care, sympathetic attention and humane treatment", and if not, why not. First, let us consider wherein and why the ward patient himself differs today from those of an earlier and perhaps better day of one or two decades ago, how socially he constitutes a different problem for the interne of today.

NEWER GROUPS OF PATIENTS

Theoretically, the New Deal has done away with the appreciative, though totally indigent, ward patient. Now, those individuals found in our wards come under one of four general classifications:

1. The white collar patient;
2. The government-made alphabetical pauper (E. R. A., P. W. A., C. C. C., L. W. D. and C. W. A. patients);
3. The employees compensation patient; and,
4. The veterans.

The first group, the white collar ward patients, as late as September, 1929, was to be found in private or semi-private rooms. Perhaps it is no fault of his own that he now has to ride "second class", but, because he does, he is more of a problem to the interne (and the nurse) than he was when he was found in his accustomed place. In the new situation he may tax the interne's tolerance to the utmost.

The Government's alphabetical pauper, or the second class, representing a mixture of the old ward patient, who paid what he could, and the truly indigent and delightful charity patient, from whom the hospital expected and got nothing, now has his hospital expenses inadequately paid by his Government, but believes that the hospital is actually making a profit by his presence therein. For this reason this type has changed. He is very unreasonable and tends to make unnecessary, if not impossible, demands of the interne and the entire hospital management.

*(*Papers & Speeches, 1931, page 385.*)

The compensation patient, on the other hand, approaches more nearly the full pay ward patient and is probably the least problem socially to be found there.

Our fourth type, the veteran's patient, comes and goes with a chip on his shoulder. He is transferred as soon as possible to a Veterans' Hospital where he meets government-paid internes and nurses. Hence, he is a problem for only a short time.

It is beyond the scope of this paper to discuss the justification for all these changes in the types of our ward patients. Whether or not they are remnants of the old deal or products of the new, certainly the responsibility for this situation does not rest with the interne. Undoubtedly this state of affairs does add to the difficulties of the interne (and of the nurse), and may, at times, appear to exceed his human endurance. It would seem that it has all led to a lessening of mutual respect between the interne and the patient. By this very token, however, the young physician is given opportunity (and often paid for it) to study and observe individuals who may be considered the replicas of patients whom he will meet later in private practice.

INDIVIDUALITY OF DOCTOR AND OF PATIENT

The writer is also aware of the fact that internes of today, as well as of yesterday, differ individually just as do ward patients. They, like their patients, have suffered economic distress not of their own making. They have their ups and downs. Some are good and get better; others are bad and get worse. Many are gentlemen born, humanitarian, and full of the milk of human kindness. A few, armed with a diploma in medicine, are arrogant and disdainful, and too ready to dictate domineeringly to their sick wards, and exact obedience unmercifully of them, as though they were rookies under a hard-boiled drill-sergeant. True enough, few of even the best of them may be the prototypes of an Osler, a Trudeau, a Riesman, or a DaCosta. However, all of them represent our profession of tomorrow and are an important criteria by which, fortunately or unfortunately, our hospitals are judged for good or for bad. If this be true, then for humanity's sake, for the good of the profession, and of the hospitals, as well as for the interne's future success as a practicing physician, let him start his career as an interne with the right perspective toward the patient. May he take up his ward work with a degree of humility and respect for the living sick, which will surpass that which four years earlier was exacted of him when he was permitted to begin his study of medicine by a dissection of the bodies of the still dead. May he never forget that the ill and unfortunate ward patient has much to give him—perhaps more than he can return. May he remember that a kind word here, and a pleasant gesture there, a little more time and gentleness in removing a dressing, in passing a catheter, in palpating a prostate, or even giving a hypodermic, may, in the patient's mind, make for the difference between a good and a bad doctor.

Finally, in this day of confusion, it certainly seems the more imperative that those of us who are charged with hospital responsibilities in the capacities of chiefs of service, assistants, and associates, should, by precept and example, continue the interne's training in his human relations of medicine.

ERYTHROBLASTIC OR MEDITERRANEAN ANEMIA

By H. Austin Vogel, M.D., Elizabeth, N. J.

Read before the Section on Radiology at the Annual Meeting of The Medical Society of New Jersey, at Atlantic City, June 7, 1934.

Osseous changes are very pronounced in certain types of anemia such as erythroblastic and sickle cell anemia; and are therefore of particular interest to the roentgenologist. They have been infrequently reported, hence the added interest.

Erythroblastic or Mediterranean anemia occurs in those races bordering the Mediter-

ranean, whereas sickle cell anemia is closely associated with the negro race. Like the majority of cases reported, the one I wish to report is of Italian extraction.

CASE REPORT

The patient, a male child 6 years old, was admitted to the pediatric service of the Elizabeth General Hospital on February 2, 1933, and was referred to the x-ray department for examination of the osseous frame. Examination of the child shows a rather frail and sallow appearing boy, with a mongoloid appearance. The malar eminences are prominent. Pupils react to light and accommodation. Nose and ears negative. Reflexes normal. Mild cervical adenopathy. Lungs negative. No cardiac enlargement noted, although a systolic murmur is heard. Liver is enlarged several fingers below costal margin and the spleen is also enlarged, being readily palpable. Many teeth are absent and caries is pronounced, which may account for the cervical adenopathy. The fauces are mildly injected.

Past history is largely irrelevant. Patient had pneumonia at three years and subsequently measles and pertussis. Appetite has always been poor. Parents are alive and well and there are three sisters, all well.

The blood examination on February 3 shows the following:

White blood cells—8,700
Red blood cells—2,980,000
Hemoglobin, 24.03%; Color Index, 0.4
Icteric Index—9
Clotting time 3½ minutes
Bleeding time 6½ minutes
Differential cell count:
Polymorphonuclears 56
Monocytes 7
Lymphocytes 37

There were present:
Marked achromia (diminished staining quality of red cells due to deficient hemoglobin)
Anisocytosis (inequality and irregularity of size)
Poikolicytosis (irregularity of shape)
Macrocytes (large red cells)
Microcytes (small red cells)
Polychromasia (stainable with many stains).

Subsequent blood examinations were made, but only slight changes were found.

The entire skelcton was x-rayed on February 4 and shows very definite and characteristic changes. A thinning of the cortex and striations was noted in the long bones and also in the vertebrae, ribs, pelvis, clavicles and small bones of the hands and feet. The skull shows a definite thickening in the frontal and occipital regions, the thickening being particularly evident in the middle and outer tables, with striations at right angles to the inner table.

Owing to the familial tendency noted, the remaining children in the family were radiographed, but no trace of any osseous change suggesting this type of anemia was found. An accurate account of the condition of near relatives residing in Italy is unobtainable.

The differential diagnosis rests principally between the hemolytic anemas, so termed by Cooley, such as sickle cell, and the congenital hemolytic form. These present somewhat similar changes though not as marked. The blood examination in sickle cell anemia will differentiate it; while in congenital hemolytic anemia reticulated red cells are more numerous than in the other varieties, and the spleen and liver do not usually attain as large size while splenectomy frequently brings about improvement. Patients with congenital hemolytic anemia are not confined to those of Mediterranean extraction.

In concluding, it is generally agreed that certain definite changes are seen in the osseous frame in Mediterranean anemia which are quite characteristic and generalized, consisting of thickening in the frontal and parieto-occipital region of the skull involving particularly the middle and outer tables. Thinning of the cortex with striations is seen in the long bones and the remainder in the skeleton. X-ray treatment is considered the more valuable method of treatment, administered over the spleen.

A STUDY OF SCHOOL PHYSICIANS' SALARIES

By ALLEN G. IRELAND, M.D.,
Director of Physical and Health Education, N. J. State Department of Public Instruction, Trenton

Although we knew in general the status of the salary question, and our predictions as to outcome were not difficult, the actual findings of our study were more startling and revealing than were expected. Great differences in salaries were known to exist, for example, but not to the extent actually found. In all school groups the range between the lowest and the highest salaries is several hundred per cent, and in at least one instance it amounts to 3000 per cent. Obviously an impossible situation exists. A mere glance at the following tables will suffice to reveal the urgent problem we are facing. It is one calling for the most careful type of investigation and for close coöperation with educational authorities.

TABLE 1

SUMMARY OF GENERAL FINDINGS

1. No. of school districts in the study . . . 489
2. No. of districts employing only part-time physicians . . . 485
   - One physician . . . 454
   - Two physicians . . . 16
   - Three physicians . . . 8
   - Four physicians . . . 1
   - Five physicians . . . 5
   - Six physicians . . . 2
   - Seven physicians . . . 1
   - Nine physicians . . . 2
3. No. of districts employing both part-time and full-time physicians . . . 4
4. Total number of individual physicians in study . . . 584
5. No. of districts using the annual salary basis . . . 433
   - Per cent of total . . . 88.6%
6. No. of districts using the per pupil fee basis . . . 52
   - Per cent of total . . . 10.6%
7. No. of districts using the per call fee basis . . . 2
   - Per cent of total 34%
8. No. of districts paying on a basis of service rendered . . . 1
   - Per cent of total 16%
9. No. of districts using a dual basis of per hour and per call . . . 1
   - Per cent of total 16%

TABLE 2

BASES UPON WHICH SALARIES ARE PAID

Pupil Enrollment	Number of Districts	Number Part-Time Physicians	Number Full-Time Physicians	Number of Districts and Salary Bases: Annual Salary	Fee per Pupil	Fee per Call	Paid for Services	Per Hour and Call
200 and less	99	99	0	86	10	1	1	1
201- 500	155	158	0	135	20			
501- 1000	91	92	0	77	13	1		
1001- 1500	47	47	0	39	8			
1501- 2000	21	23	0	21				
2001- 3000	31	36	0	31				
3001- 4000	11	24	0	10	1			
4001- 5000	5	5	0	5				
5001- 6000	4	7	0	4				
6001- 7000	5	14	0	5				
7001- 8000	7	16	0	7				
8001- 9000	1	2	0	1				
9001-10,000	2	3	5	2				
Over 10,000	10	50	3	10				
Total	489	576	8	433	52	2	1	1

TABLE 3

ANNUAL SALARIES OF PART-TIME PHYSICIANS

Pupil Enrollment	No. of Districts	No. of Part-Time Physicians	No. on Annual Salary Basis	Lowest Salary	Highest Salary	Median	Average
200 and less	99	99	86	$ 15.00	$ 400.00	$ 100.00	$ 115.00
201- 500	155	158	135	75.00	750.00	200.00	236.00
501- 1000	91	92	77	50.00	1500.00	300.00	412.00
1001- 1500	47	47	39	350.00	1700.00	500.00	676.00
1501- 2000	21	23	23	400.00	2000.00	900.00	919.00
2001- 3000	31	36	36	450.00	2000.00	1000.00	1043.00
3001- 4000	11	24	15	400.00	3000.00	1000.00	1050.00
4001- 5000	5	5	5	1000.00	3000.00	1300.00	1640.00
5001- 6000	4	7	7	700.00	1250.00	800.00	914.00
6001- 7000	5	14	14	350.00*	4300.00	600.00	1121.00
7001- 8000	7	16	16	500.00	2400.00	1200.00	1128.00
8001- 9000	1	2	2	600.00	600.00	600.00	600.00
9001-10,000	2	3	3	900.00	900.00	900.00	900.00
Over 10,000	10	50	50	350.00	2600.00	800.00	1067.00

* One district with seven physicians.

TABLE 4

NUMBER OF PHYSICIANS PAID ON A PER PUPIL FEE BASIS

Fee	200 Less	201 500	501 1000	1001 1500	3001 4000	Total
.30					(1) 9	9
.40		1				1
.50	1	7	2	2		12
.75	2	5	4	1		12
1.00	5	8	2	3		18
Fee not stated	2	1	5	2		10
Total	10	22	13	8	9	62*

* Represents 52 school districts.

ADDITIONAL BASES

In addition to the annual salary and the per pupil fee, four physicians are paid as follows: Two are paid on a per call basis; one is paid for service rendered; and one is paid $10.00 per hour for required service and $3.00 per additional call.

SUPPLEMENTARY COMPENSATION

A. Board of Education Pays an Annual Fee to the Physician for Vaccinations and Toxoid or Toxin-antitoxin Inoculations

Fee	200 Less	201 500	501 1000	1001 1500	2001 3000	5001 6000	7001 8000	Total
$ 25.00		1			1			2
30.00		1						1
50.00	1		1					2
100.00			1					1
125.00		1						1
150.00					1			1
200.00		1				1		2
Fee not stated		2		1			1	4
Total	1	6	2	1	2	1	1	14

Median $75.00
Average is $95.50

B. Board of Education Compensates the Physician on a Per Pupil Fee Basis for Vaccinations and Toxoid or Toxin-antitoxin Inoculations

Fee	200 Less	201 500	501 1000	1001 1500	2001 3000	4001 5000	Total
$ .10						1	1
.15					1		1
.25	2	1	1				4
.50	1		3	1	1		6
.75		1	1	1			3
1.00	1	2		1			4
1.10			1				1
1.30			1				1
Fee not stated	1	3	2		1		7
Total	5	7	9	3	3	1	28

Median is $0.50
Average is $0.61

C. No Extra Compensation for Immunization but Materials Are Furnished without Cost to the Physician

Source	201 500	501 1000	1001 1500	1501 2000	3001 4000	Total
Board of Education	2	2	2	2	2	10
Board of Health	1					1
Total	3	2	2	2	2	11

D. Board of Education Compensates Physician for Schick Test Only

1. Fees per Pupil:
   - $ .08 — 1
   - .10 — 1
   - .30 — 1
   - .35 — 1
   - 1.00 — 1
2. Annual sum in addition to salary of $500 — 1
   (For district with 2300 pupils)

E. Board of Education Remunerates Physicians on a Separate Fee Basis for Toxoid Inoculations and Vaccinations

	T. A.	Vac.
1. 200 and less	$1.00	$ .50
2. 201 to 500	2.00	.25
3. 501 to 1000	.80	.65
4. 1001 to 1500		.50
5. 1501 to 2000	.50	2.00

CONCLUSIONS

1. The study shows that further investigation is needed. It is recommended, therefore, that a special committee be appointed for the purpose; and its report be submitted to the committee on medical economies.

2. It is revealed that no tendency indicative of a standard salary of a school physician exists. Instead, there is exceedingly great divergence of salaries in school districts of approximately the same size.

ROUTINE WASSERMANN TESTS IN A HOSPITAL

By A. J. CASSELMAN, M.D., Dr. P.H., and ANABEL CADWALLADER, Camden, N. J.

About eight years ago the plan of taking a specimen of blood for a Wassermann test from every patient in the hospital was adopted by the West Jersey Homeopathic Hospital in Camden. A study was made in 1934 to determine the results obtained. Conditions for such a study seemed especially favorable at this hospital. The superintendent of the hospital and the director and technician of the Wassermann laboratory have served in their respective capacities during the entire period. At the hospital the same routine, of having the technician secure each morning the list of patients admitted during the preceding 24 hours, and of making her responsible for securing the blood from these patients, has been followed. The specimens are sent to the Wassermann laboratory each Tuesday. The technic of the Wassermann has not been materially changed during this period. Overnight cold fixation and the Nieman and Gager cholesterolized alcoholic extract of ether extracted beef heart are the essential features which make the tests extremely sensitive. The local laboratory has been checked with the State Laboratory frequently.

METHOD OF STUDY

The average annual population of this hospital is about 4000. This, of course, includes infants, minor accident cases, and others who remain too short a time in the hospital to have blood specimens taken or who for some reason were missed. It was decided to exclude from this study all persons under sixteen years of age. It was further decided that a sufficiently accurate picture could be drawn from the study of 500 Wassermann tests done in each alternating year beginning with 1927. Accordingly, information has been tabulated from the case histories of 500 patients at random on whom Wassermann tests were performed during 1927, 1929, 1931, and 1933. Enough patients had gone through the procedure in 1934 to make it possible to include this year also. This gives a total of 2500 Wassermann reports included. These are general hospital records only, and do not include any of the out-patient departments.

RESULTS OF ROUTINE TESTS

Of these 2500 Wassermann tests made over a period of seven years, 151 were positive. This indicates that about six per cent of the adults admitted at this hospital have syphilis. The number of positives varied somewhat from year to year as shown below.

NUMBER OF POSITIVE WASSERMANNS IN 500 TESTS FOR DIFFERENT YEARS

	No. Plus Wassermanns
1927	43
1929	23
1931	32
1933	24
1934	29
	151

Camden is an industrial city and many indigent patients are treated at this hospital. About half of the 2500 cases tabulated were in the general wards of the hospital. As might be expected, the percentage of positive Wassermanns from this group is higher than that of the total hospital population, or about 8 per cent as compared with 6 per cent of the total.

The following table shows the number and percentage of positive Wassermanns in different departments of the hospital:

CLASSIFICATION OF WASSERMANN-TESTED PATIENTS (500 EACH 1927, '29, '31, '33, '34)

	No. Tested	No. Positive	Per Cent Positive
Private Patients	369	5	1.3%
Gynecological Ward	212	14	6.6%
Obstetrical (Private & Ward)	653	28	4.3%
General Ward	1266	104	8.2%
Total	2500	151	6 %

As the incidence of syphilis among negroes is admittedly higher than among whites, it is interesting to note that of the 2500 patients studied only 203 were negroes. Fifty-nine, or 29 per cent of these 203 negroes tested had positive Wassermanns, as compared with 4 per cent of the 2227 white persons tested. In

seventy of the histories, the color was not stated.

SYPHILIS AND A LONG LIFE

Among the 151 patients having positive Wassermanns were three persons over seventy years of age. Curious reasons for longevity have been given; it would be interesting to know if these septuagenarians attributed long life to syphilis. Thirty-five of the 151 positive patients were over fifty. It is certain that many of these persons had acquired syphilis years before and had never known of their infection. It is equally certain that in many of the cases a diagnosis of syphilis would not have been made without the routine Wassermann test.

AGES OF 151 WASSERMANN POSITIVE PATIENTS

Age	No. of Patients
16-20	14
21-25	17
26-30	17
31-35	25
36-40	20
41-45	7
46-50	17
51-55	12
56-60	6
61-65	8
66-70	6
71-	3

THE EXPERIENCES OF TWO OTHER HOSPITALS

For purposes of comparison, figures regarding routine Wassermann tests were secured from two other hospitals in New Jersey. At the Orange Memorial Hospital, Orange, routine Wassermann tests are made only on ward patients. The internes are responsible for collecting the blood, which is sent to the laboratory of the State Department of Health for examination.

Again 500 cases were taken as the unit. Results for three years, 1932, 33, and 34, were available. The percentage of positives secured at this hospital was lower than at the West Jersey Hospital. This probably is due to the different type of population. The Orange Memorial Hospital draws from a fine residential community.

Of the first 500 Wassermanns done (in all wards except the children's ward) in 1932, 26 were positive; in 1933, 25 positives were secured; and in 1934, 16. The percentage of positives is 5.2 per cent, 5 per cent, and 3.2 per cent as compared with an average of about 8 per cent in the wards of the West Jersey Hospital.

At the Morristown Memorial Hospital, Morristown, routine Wassermann tests are made on both ward and private patients. Tests are run in the hospital laboratory. Hospital records showed that 3113 Wassermann tests had been done on hospital patients during the four years 1930-33. Of this number 163, about 5 per cent, were positive. The ward patients ran about 6 per cent positive as compared with 3.5 per cent positive among private patients.

SOME RESULTS DIFFICULT TO MEASURE

The obvious benefit from routine Wassermanns in a hospital is the discovery of infected persons who would otherwise be missed. There are many persons admitted to hospitals without stigmata of the disease.

The educational value of this routine, although more difficult to measure, is important. The internes may have the experience of taking the specimens and of learning the patient's reaction to a blood test. The rebellious patient must be mollified, and the reason for taking the specimen must be explained to others. In private practice, the decision as to whether or not to explain to the patient the purpose of the test requires discrimination and the explanation should be tactfully made. Experiences gained in the hospital are helpful in private practice.

A highly desirable change in the attitude of

ROUTINE WASSERMANN TESTS AT THE MORRISTOWN HOSPITAL

	Ward Patients			Private Patients			Total Hospital Patients		
	Number Tested	Number Pos.	Per Cent Pos.	Number Tested	Number Pos.	Per Cent Pos.	Number Tested	Number Pos.	Per Cent Pos.
1930	540	40	7.4%	155	6	3.8%	695	46	6.6%
1931	624	42	6.7%	139	9	6.4%	763	51	6.6%
1932	512	18	3.5%	293	8	2.7%	805	26	3.2%
1933	546	31	5.6%	304	9	2.9%	850	40	4.7%
	2222	131	5.9%	891	32	3.5%	3113	163	5.2%

the public towards a blood test will result inevitably from the practice of making Wassermann tests a part of the hospital routine. Today many people are affronted at the suggestion of a blood test because "bad blood" has been associated with promiscuity. It will not be many years surely before the patient will accept the physician's recommendation of a Wassermann test as matter of factly as he now does a urinalysis.

SUMMARY

A study of the records of the West Jersey Homeopathic Hospital, Camden, to determine the value of routine Wassermann tests indicated that about six per cent of adults admitted to the hospital had positive Wassermanns.

Twenty-five hundred cases were included in the study, 500 from records of 1927, 29, 31, 33 and 34. About half of these cases were in the general wards of the hospital and, as was to be expected, the number of positive cases was greater among this group. About eight per cent of the general ward patients had positive Wassermanns recorded as compared with six per cent of the hospital population.

Only 203 of the 2500 cases studied were negroes. Of these, 59 (29 per cent) had positive Wassermanns as against four per cent of the 2227 white persons.

Statistics secured for comparison from two other hospitals in different sections of the State indicated a somewhat lower incidence of syphilis among patients admitted. This is probably due to the different type of population. At the Orange Memorial Hospital routine Wassermanns are done on ward patients only, with about four per cent positive results since 1932. At the Morristown Memorial Hospital about five per cent positives have been secured on 3000 ward and private patients tested since 1930.

FOETAL MORTALITY IN BREECH PRESENTATIONS

HINTS IN CONDUCTING THE BREECH DELIVERY

By FRANK J. GOFF, M.D., Red Bank, N. J.

Read before the Monmouth County Medical Society at Allenhurst, November 28, 1934.

The reason for this paper was the realization of the high foetal mortality in breech deliveries. The next step was to ascertain just how high the mortality was. This led to an analysis of a total of eighty cases which occurred at the Monmouth Memorial Hospital in the last five years (1929-1934). Twenty-two still births occurred (see chart No. 1), or a gross mortality of 27 per cent. When corrected by deducting nonviable prematures (under 1500 Gms.), monstrosities and the leutic foetus, the mortality was 15 per cent.

However, twelve of these deaths were due to the technic of the delivery. Three were caused by intra-cranial injury when the forceps were applied to the head. In one instance, a large part of the placenta was made up of a white infarct (fibrotic organization of the

CHART NO. 1

ANALYSIS OF 80 CASES OF BREECH PRESENTATION

22 Stillbirths *Gross Mortality 27%*

6	Non-viable Prematures Under 28 weeks and less than 1500 grams.
3	Monstrosities and Spina Bifida 2 Anencephalic 1 Hydrocephalic (Craniotomy)
1	Macerated Foetus (4+)
10	

3	Intracranial Injury (Forceps) (Used six times in series of eighty cases)
1	White Infarction of Placenta Fibrotic organization of one-third of total
1	Red Infarction of Placenta Premature separation of
2	Inspirated Amniotic Fluid Definitely breathed with head not delivered
4	Asphyxia Due to Compression of Cord
1	Unknown
12	

Corrected Mortality 15%

placenta). As recently stated by Trout,[12] "Placental lesions of sufficient extent suggest the possibility of their contributing in part, at least, toward the infant's death before birth." The inference is that so much of the placental circulation is cut off that the foetus is asphyxiated. Another cause of death was premature separation of the placenta with hemorrhage from the placental site, causing asphyxiation. In two cases the foetus definitely breathed with the head in utero, causing the baby to inspire amniotic fluid. Four cases occurred where the cord prolapsed with the descent of the breech, cutting off the foetal circulation and exciting respiratory efforts.

These figures do not compare badly with the reports from other institutions. (See chart No. 2.) J. W. Williams says the usual

CHART NO. 2

COMPARISON OF MORTALITY RATES

	Gross	Corrected	Delivery
Williams	..	10-15%	
Monmouth Memorial	27%	15%	Spontaneous
Cleveland	19.2	6%	Radical
Philadelphia	35.4		Radical
Chicago	11%	7%	Spontaneous
Sloan's	21.7		Spontaneous
Margaret Hague	17.2	12.8	Radical

mortality is between 10 and 15 per cent. At Cleveland, where the handling of these cases is extremely radical (elimination of the second stage), the figures are 19.2 per cent and 6 per cent. At the Philadelphia Lying-In Hospital, where the treatment in the majority of cases is radical, the reported figures are 35.4 per cent for gross mortality. Chicago had the best results (11 per cent and 7 per cent) with the majority of the breech cases being born spontaneously with a minimum of assistance from the operator (318 out of 487). At the Sloan Maternity Hospital the method is Spontaneous to the Umbilicus, and their gross mortality is 21.7 per cent. At the Margaret Hague Hospital at Jersey City the mortality rates are 17.2 per cent for the gross and 12.8 per cent for the corrected; and the method of delivery is "decomposition and extraction" when the cervix is fully dilated.

A very serious complication of breech deliveries is the high frequency of premature babies. Reports range from 10 to 24 per cent.[7][8] Premature babies do not stand the shock of delivery well; and as a result the mortality rates are high in this group. A few imperative points to remember are:

1. Apply warm towels to the presenting part to prevent inspiration of amnotic fluid (drowning).

2. Make traction by the legs and not on the abdomen because of the danger to the abdominal organs, such as the liver, adrenals, etc.

3. Gentleness in handling the foetus because of the dangers of fracture of the humerus, cervical vertebra, etc.

4. Avoid delay in delivering the head.

5. Be mindful also, especially if forceps are used, of the occurrence of intra-cranial injury.

EARLY DIAGNOSIS

Now that I have given you the figures and the complications, I would like to bring out a few points which might be helpful. First, make an early diagnosis. Studdiford[3] says that "50 per cent of breech presentations are not recognized until the time of delivery". The values of an early diagnosis are manifold.

External version without anesthesia and attempting to maintain it as such is successful in 80 per cent of the cases.[3] It can be done about the 32nd or 34th week. If not successful, there is usually a very definite cause such as contracted pelvis (55 per cent).

X-ray is one of the most important methods of diagnosis in the armamentarium of an obstetrician. We all realize the fact that eternal pelvimentry is inadequate; but, since the recent work of Herbert Thoms at Yale,[6] we all should appreciate the value of stereoscopic examination. The above writer claims that x-ray should be part of the pre-natal care of every primipara. It should be used to verify the presentation; to see if our external version is successful; and repeated again at the expectant date to note if any disproportion exists between the vertex and the pelvis. It is very embarrassing not to know of a disproportion until the last phase of the extraction.

If any disproportion exists, not only due to a moderately contracted pelvis, but, especially if the foetus is large (over 8 lbs.), a Cesarean is indicated, particularly if the mother is an elderly primipara.

Having decided to allow your patient to go into labor, do not do vaginals or rectals because of the possibility of rupturing the membranes early. This may lead to prolapse of a foot, which makes a very poor dilating wedge; or even the prolapse of the cord with the subsequent cutting off of the foetal circulation.

Keep your patient in bed and do not make her "walk". Support her strength by adequate diet, fluids, etc. Gwathmey rectal anesthesia has a very definite place in breech deliveries. Examinations of foetal heart rate are indicated every fifteen minutes, so that at the first sign of danger extraction can be performed.

SECOND STAGE OF LABOR

As to the conduct of the second stage a wide divergence of opinion seems to exist. At Dr. Arthur H. Bills' Clinic in Cleveland and at Dr. E. P. Piper's Clinic at the University of Pennsylvania, the second stage is eliminated. Extraction under deep anesthesia by conversion into a double footing after ironing out the perineum is advocated. Whereas, at Sloan's Hospital in New York and at the Chicago Lying-In Hospital the "Spontaneous to the Umbilicus" treatment is advocated. Each claims their figures are low. The radical group says the foetal deaths are due to compression of the cord; the conservative group says the mortality is due to intra-cranial hemorrhage, fractured cervical vertebra, nuchal arms, causing delay in delivery, and aspiration of amniotic fluid.

DELIVERY

As a basis for discussion, let us advocate the following technic of delivery, providing a rapidly failing foetal heart does not warrant haste; i. e., Spontaneous to the Umbilicus. Then if the back is posterior and the baby is sitting in the hollow of the sacrum, by traction under deep anesthesia deliver the arms following nature's mechanism, the posterior arm first, and then the anterior, aiding by sweeping the hand over the scapula and down the arm. Do not do any more twisting and turning than necessary.

To deliver the head, let us advocate the Wiegand maneuver, i. e., fingers of the left hand in the baby's mouth and supra-pubic pressure. J. W. Williams[1] says he never found it necessary to use the Piper forceps providing the anesthesia was deep enough and an ample episiotomy was done. The Mariceau-Smellie-Viet maneuver is dangerous because of traction on the foetal shoulders causing an Erbs palsy due to injury to the brachial plexus.[3]

In conclusion, let me summarize the important points again.

1. The foetal mortality rate in breech presentations ranges from 6 to 15 per cent.
2. Common occurrence of premature labors in breech presentations—25 to 50 per cent.
3. Early diagnosis and external version.
4. X-ray at expected date for any disproportion.
5. Section is indicated in some breech presentations.
6. In the first stage do no vaginals, keep mother in bed and support her strength.
7. In the second stage, let us advocate expectant treatment with spontaneous delivery to the umbilicus; deep anesthesia for delivery of shoulders and the Wiegand maneuver for delivery of the head.

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THE CRAMPTON TEST AND SURGICAL SHOCK

By JOHN H. IRWIN, M.D., Englewood, N. J.,
Attending Surgeon, Englewood Hospital, Englewood, N. J.

Surgical shock is often unexpected, rapid and fatal. If there were a pre-operative sign of a tendency toward post-operative shock it would be most welcome for several reasons:

1. The operation might be avoided or delayed pending improvement.
2. Special emergency preparations for treatment of shock might be made.
3. If the tendency to shock could be discerned, steps could then be taken to apply preventive measures if such might be discovered.

At the Englewood Hospital the surgical service of A. W. Ward, M.D., offered an opportunity to study this matter, at the time the attention of the writer was called to the Crampton Test and Index.[1] This test evaluates an important element in circulatory efficiency which Crampton calls "the gravity resisting ability". It represents an index which is high in persons exhibiting sound health, notably in athletes in good condition. It is low in illness, and lowest in persons very sick, as for example, in terminal nephritis, myocarditis, diabetes.

There are some instructive exceptions of masking pathological overtone which Crampton has pointed out, and noted by us in cases of hyperthyroidism and abdominal tumor; otherwise the index in general reveals the "condition" of a most important factor in the patient's circulatory efficiency and, so far as we have observed, with striking faithfulness. It shows the effects of changes in room temperature on the circulation;[2] it has been recently adopted as a standard for disqualification from athletics by the Intercollegiate Amateur Athletic Association of America;[3] it indicates the improvement of cases of heart disease from rest in bed,[4] etc.

It is apparently a test of "the efficiency" of splanchnic vaso-tone upon which the integrity of the whole circulation depends;—a useful addition to the routine symptoms of temperature, heart rate, blood pressure, etc.

TECHNIC OF TEST

This test consists in making a comparison between difference in the systolic blood pressures of the patient lying and standing, and the similar difference in the heart rates. Pulse and blood pressure are taken lying down. The patient then stands for two minutes and the pulse and blood pressure are taken again. If on standing the systolic pressure falls, it indicates weakness; to the same degree, a rise of the heart rate on standing is a sign of relative failure. For clinical convenience, Crampton made an approximate balancing of these significant symptoms and devised a scale which indicates the *Crampton Value.*

On this scale 100 is theoretical perfection, seldom noted. Seventy-five is excellent, 65 and below poor. The indices run below zero into the minus range, and in our series as low as minus 100. (See chart, p. 417.)

THE PROBLEM

We desired to see if this test would show a tendency to surgical shock. We, therefore, endeavored to take the Crampton Value on every case entered for operation unless the patient was too sick. This was done on 345 consecutive operative cases, with the aforementioned exception.

DATA

These cases were distributed as follows:

CHART II

	Number of Cases
Prostatectomy	11
Appendectomy	121
Hystorectomy	18
Vaginal Repair	11
Salpingectomy	17
Hernia	41
Inc. and drainage	19
Gastroenterostomy	6
Gastroplasty	1
Duodenojejunostomy	1
Cholecystectomy	18
Spleenectomy	1
Amputations	2
Mastectomy	3
Dilation and Currettage	2
Rectal operations	16
Empyema	1
Osteomyelitis	6
Nephrectomy	2
Other operations	48
Total	345

A table of Crampton Values is shown in the adjacent column. Locate the column under the figure showing the increase, or decrease, in blood pressure.

Then locate the figure on the left column indicating the increase or decrease in pulse rate. Follow the column down and the line across the page, and their junction will show the Crampton Value.

ANALYSIS OF DEATHS

In this series of 345, there were 15 deaths. Three of these were in shock. One of these had shown a zero record, the second a minus 80 record, and the third had been too sick to record the Crampton Value.

CHART III. ANALYSIS OF DEATHS

	Diagnosis	Time of Death After Operation	Crampton Value Before Operation	Age
1.	Perf. gastric ulcer	3 days	75	65
2.	Ca. of stomach	21 "	75	67
3.	Stone in ileum	4 "	15	70
4.	Perf. of diverticulitis	2 "	None, too sick	70
5.	Tbc. abscess of omentum	60 "	80	56
6.	Ruptured ectopic	4 "	None	37
7.	Ca. of peritoneum	30 "	30	61
8.	Acute appendicitis	21 "	None	22
9.	Strangulated hernia	3 "	None	54
10.	Ruptured appendicitis	4 "	None	43
11.	Strangulated hernia	3 "	None	62
12.	Gangrene of intestine	4 "	55	45
13.	Cholecystectomy	1—Shock	—80	66
14.	Cholecystectomy	1—Shock	0	48
15	Osteomyelitis	On table—Shock	None	24

It will be seen that the cases showing the two lowest Crampton Values in the whole series died in shock. Of three others with low values of 15, 30, and 55, two died in four days with gangrene of intestines and stone in the ileum, and the other died a week after with carcinoma. All these patients were sick before operation, and the vasotone was impaired but not so much impaired as those who were to die of shock.

HEART RATE

Increase per Minute on Standing

Decrease on Standing	Blood Pressure Increase in Mm. of Mercury on Standing: 16-15	14-13	12-11	10-9	8-7	6-5	4-3	2-1	Decrease in Mm. of Mercury on Standing: 0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	21-22	23-24
8-12	130	125	120	115	110	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30
4- 8	125	120	115	110	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25
0- 4	120	115	110	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20
0- 4	115	110	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15
5- 8	110	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10
9-12	105	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5
13-16	100	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0
17-20	95	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5
21-24	90	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10
25-28	85	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15
29-32	80	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20
33-36	75	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25
37-40	70	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30
41-44	65	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35
45-48	60	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40
49-52	55	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45
53-56	50	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50
57-60	45	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55
61-64	40	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55	—60
65-68	35	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55	—60	—65
69-72	30	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55	—60	—65	—70
73-76	25	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55	—60	—65	—70	—75
77-80	20	15	10	5	0	—5	—10	—15	—20	—25	—30	—35	—40	—45	—50	—55	—60	—65	—70	—75	—80

Another death of interest is reported by Walter Schmidt, M.D., of Cliffside Park, New Jersey.

A young woman came to his office with vaginal bleeding and after examination, he discovered that she had fibroids and recommended a hysterectomy. However, he took a Crampton Value and found that it was minus 10, so he advised her to wait until she improved in health before the operation, and outlined treatment. About eight days later he was going past her house and noticed a funeral. On inquiry, he found that she had gone to another hospital, was operated on the next day and died from post-operative shock.

To sum up: We find that the only recorded deaths of shock, where Crampton Values were taken, showed very low values before operation. Not one with a high index before operation died of shock.

PROPHYLAXIS OF SHOCK

Our purpose was not only to see if shock could be foreseen, but also to see if it could be forestalled and prevented. At the beginning of our series we naturally assumed the hypothesis that a low Crampton Value might mean a tendency to shock. In testing this thesis scientifically, however, we could not forget our duty to our patient; and so we sought ways of prevention and applied them in all low Crampton Value cases except in emergencies as reported, reserving none for the usual statistical control by comparison. Only emergencies (or the fatal willfulness of the patient, as in the case reported by Dr. Schmidt) provided our statistical contrast, and these were the only cases that died in shock. Had we not employed our prophylactic measures in a fairly large number of other low value cases (Chart IV) we might have had other shock deaths. We will never know. While this negative evidence is scanty, though vivid, the positive evidence is more ample. The methods we employed were based on the fact that Crampton stated in his lectures at the Post-Graduate Hospital, 1927, et seq., in a further discussion of the test [5] that digitalis, and sometimes squill, would bring up a low Crampton Value. He stated digitalis would first reduce the systolic pressure difference, next the pulse rate difference, and lastly the diastolic difference, all depending upon the capacity of the circulation to react. From an entirely indifferent source, however, our attention was called to the experiences of A. W. Ward, M.D., Chief of a Surgical Division of the Englewood Hospital, who, without knowledge of the Crampton Test, had begun to use digitalis empirically in weak patients preparing them for operation. He got good results. "The patients improved in tone and did well."

Accordingly, we adopted the following course. If possible, all patients were given the Crampton Test. All who showed a rating below 65 were reserved from operation and digitalized until the test rose above 65. Two results were definite.

1. We verified Crampton's statement that digitalis would raise his index.

2. We experienced no case of shock and we did not lose a patient. Whether or not we would have had shock and lost a patient without digitalizing no one will ever know, but the patients lived.

CHART IV. TYPICAL CASES SHOWING CRAMPTON VALUE AND IMPROVEMENT FROM DIGITALIS

Operation	Crampton Value Before Digitalis	Crampton Value After Digitalis	Result
Fissure in ano	minus 100	plus 65	Good
Hernia	plus 65	" 75	"
General repair	" 35	" 85	"
Hernia	minus 15	" 80	"
Hernia	" 50	" 90	"
Gastroenterostomy	plus 50	" 70	"

We must remember that these cases received also rest and hospital care as well as digitalis, and their condition did not compel immediate operation.

CHART V. TYPICAL CASES NOT DIGITALIZED BEFORE OPERATION

Operation	Crampton Value	Result
Cholecystectomy	85 no digitalis	good
Femoral hernia	80 " "	"
Hysterectomy	100 " "	"
Salpingectomy	100 " "	"
Cholecystectomy	80 " "	"
Cholecystectomy	65 " "	"
Hysterectomy	70 " "	"

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CHRONIC LUMBO-SACRAL BACKACHE

By H. Eugene Reading, M.D., New York, N. Y.

Read before the Clinical Society of the Paterson General Hospital, October 18, 1934.

The subject of low back pain has until recently been one of the neglected phases of orthopedic surgery from the standpoint of pathological study, to be correlated with clinical findings.

If we assume that man evolved from the primates, until the gradually erect posture was attained, one can readily appreciate the undue stress and strain produced at the lumbo-sacral junction, and secondarily, at the sacro-iliac joints. The skeletal remains of the Neanderthal man showed a slight convexity of the lumbo-sacral angle, as contrasted to the concavity at the lumbo-sacral spine in *Homo Sapiens*. One of the many blessings which befall the human is the painless fusion of the sacro-iliac joints occurring after the age of forty. This is a compensatory measure for the gradual lessening of muscle tone beyond the fourth decade of life.

A brief summary of the anatomy of the lumbo-sacral junction is important; there are three joints between the fifth lumbar and first sacral bodies; an incomplete joint consisting of a hollowed area between the vertebral surfaces respectively, and lined by cartilage. Between these two hollowed or cup-shaped surfaces is the thick inter-vertebral disc, functioning as a buffer against jarring. The other two joints are the articulating processes; one on either side of the vertebral disc, set into its respective facet and covered by synovial membrane.

There are strong ligaments attaching the vertebra to one another; an anterior and posterior common longitudinal ligament; two ligaments between each spinous process (inter and supra spinous); the ligamentum flavum consisting of broad tough flat bands between the vertebral arches. The ilio-lumbar ligaments are situated between the transverse processes of the fifth lumbar body and the posterior iliac crest, and, lastly, the lateral lumbo-sacral ligaments.

The muscles of the lower back are unequally distributed, since there are no strong supporting muscles anterior to the spine. The psoas major muscles laterally and the long erector spinae group posteriorly, perform the essential functions as they traverse the lumbo-sacral junction, while the multifidus and quadratus lumborum are secondary.

The nerves of importance in the lumbo-sacral region are the anterior and posterior primary divisions of the fifth lumbar nerve and a portion of the anterior primary division of the fourth lumbar nerve. These nerves traverse this important area through relatively small intervertebral foramina. Because the roots of the fourth and fifth lumbar nerves *"*do not possess arachoid coverings"* sufficient congestion of circulatory or synovial origin produced by arthritis, trauma or postural deviations may cause various degrees of irritability to the neighboring nerve structures with resultant pain. Trauma or disease of the articulating processes or their facets in the lumbar region, which is not uncommon, will produce a local synovitis, especially during an acute or subacute phase. Occasionally one may see a small raised circumscribed area of the skin over the region of an articulating facet with a fluctuant feel. Gentle digital pressure over such a swelling is quite painful to the patient. Incidentally, counter-irritation to such an area affords rapid temporary relief. Pressure on the fifth lumbar nerve may be responsible for prolonged sciatic pain.

An arbitrary classification of etiological factors in the production of lumbo-sacral pain is used here for purposes of simplification:

1. Congenital anomalies of the lumbo-sacral region predominate in varying degrees when compared with the number of anatomically perfect lumbo-sacral regions. Therefore instability of the spine at this level can be appreciated when one bears in mind the severe stress and strain to which the lumbo-sacral level is subjected. In many, though

* Benoit & Forestier.

not all instances, a tuft of hair over the skin of the lower back often suggests a congenital anomaly of the articulating processes, the lamina, one or both transverse processes of the fifth lumbar vertebra articulating with or fused to the sacrum, etc.

This class of patients depends to a greater degree upon good tone of the back muscles than does a person with a normally developed spine. Low back pain appears in congenital anomalous spines following rapid loss of muscle tone, after a debilitating disease or prolonged muscular inactivity. The gradual change in posture during pregnancy, with a reversion to normal posture weeks or months after the birth of the child, may bring about chronic low back pain in a good number of mothers. Slight mobility at the symphysis pubis may transmit strain directed at one or both sacro-iliac joints. This clinical observation may be verified by a roentgen study with the patient first standing on one foot, and a second flat film made when she stands on the opposite foot. It is not uncommon for a patient in this anomalous class to date the history of her low back pain following an operation under a general anesthetic, when the thoroughly relaxed back muscles are strained due to an abnormal position of the patient on a hard surfaced operating table.

II. *Metabolic Disturbances*: The average orthopedic surgeon experiences disappointing results in attempts to relieve backache in patients who come under this classification. The proof of this statement is borne out in the doctor's case records, which commonly note that such patients have or will eventually visit more than one doctor's office or clinic in search of relief and ultimately resort to osteopathy or chiropractic. A few of such patients do improve under the care of a level headed person, following either of the latter callings, as a result of manipulation, augmented with much more psychology. Unfortunately relief is not lasting in most of them, the patient so often returning to the family physician or surgeon.

A thorough history and physical examination on the part of the general practitioner or internist has been of great help in formulating a successful outline of treatment. For instance, a patient with a hypothyroid condition or an adrenal insufficiency will complain of bodily fatigue, out of proportion to the day's activities. In the former type, poor muscle tone of the back can account for severe low back pain in the absence of other clinical evidence. The status hypoplasticus of thymic origin reveals a patient who commonly suffers from low back pain. He or she usually possesses shallow joint cavities and this applies also to the inter-vertebral joints, with the potential possibility of an unstable lumbo-sacral junction.

A contrast of this patient is the pituitary type inclined to be thick set and overweight, with lessened joint mobility, there being limited motions of the spine, especially in lateral bending.

Lastly, in the spasmophilic tendencies displayed by patients with parathyroid dysfunctions, they cannot obtain relief from muscle spasm unless specific glandular therapy is prescribed. Low back pain in this type is usually inconsistant. The psychiatrist usually classifies patients grouped here under "Metabolic Disturbances" as properly belonging to the class of neurasthenics. He is justified in his latter diagnosis as evidenced by relief or "cures" obtained through psychotherapy only.

III. *Trauma*: Back strain directed at the lumbo-sacral junction is one of the commonest of the minor back injuries, which may at first pass off after several days and leave the patient comfortable, even though he may not have had medical aid. However, recurrence of the back pain is the rule. In these patients x-ray findings may be negative immediately after injury. Nevertheless, the importance of a careful x-ray study should be borne in mind, since the conventional antero-posterior and lateral views will not uniformly reveal trauma or pathology to the articulating processes or the articulating facets of the luinbo-sacral spine. Valuable information can be gained from an oblique view of the spine, and in cases where there is a question of anomalous position of the transverse processes of the fifth lumbar vertebra, a 45° angle film may

clear up an otherwise undiagnosed case of chronic lumbo-sacral pain.

Arthritic changes of the articulating processes or their facets may commonly follow low back injuries, and may not be evident in the x-ray study until many months after the original onset of pain. The lateral view of the lumbo-sacral junction permits one to study the angles at this level, which vary to a considerable degree in different subjects. This latter finding, depending upon its variation from the normal, may often reveal the etiology of chronic low back pain of long duration. There is difference of opinion amongst anatomists as to the normal sacro-vertebral angle, probably because of the various methods used in determining the numerical ratio. For general purposes it may be considered that the sacro-vertebral angle is approximately 135° in the female and about 138° in the male.

Spondylolisthesis, the term used for slipping forward of the fifth lumbar vertebra, may vary to a moderate extent as it presents at the sacro-vertebral angle. Many anatomists and orthopedic surgeons consider this condition to be congenital in origin and manifests itself clinically after injury or loss of tone of the back muscles. The recently coined term "prespondylolisthesis" is reserved for those cases having the potential possibilities of the fifth lumbar vertebra actually slipping forward at some future time because of anomalies of the articulating processes or their facets. Recent publications by two independent authors have called attention to the possibilities of a slight *posterior* displacement of the fifth lumbar vertebra on the sacrum, as a cause of persistent lumbo-sacral pain. Anomalies of the articulating facets betwen the fifth lumbar and first sacral vertebra, either in their confirmations or their angles are considered the important causative factors. One (*) author treated the majority of his cases conservatively, whereas the other writer (**) had preference to operative fusion of the lumbo-sacral spine.

Quite frequently treatment must be prolonged in those cases having hemorrhage of varying degrees in the gluteal muscles, or about the nerve root branchings, such as the fifth lumbar, the first or second sacral. Persistent pain is experienced by these patients who may have the additional spasm of the pyriformis muscles. Although it is not a large muscle, it is in close anatomical relationship with the sciatic nerve. Therefore spasm of the pyriformis muscle, together with ensuing circulatory congestion is sufficient to cause irritation, transmitted to the branchings of so large a nerve. In the early stages there may be a lessened ankle jerk on the same side, while in chronic cases the ankle jerk may be absent. Appreciable muscle atrophy of the entire lower extremity rapidly follows, usually associated with sensory changes.

Common examples of this type of trauma occur as a result of falling and sitting down with a thump. Slow progressive hemorrhage about the lowermost levels of the spinal cord, or their nerve branchings, may follow in some cases. In male subjects one must be guarded in prognosis, because of the possibility of the loss of penile erection, which may or may not eventually reappear. Psychoses of a severe nature have not infrequently resulted. Women have the unhappy faculty of commonly tripping on a staircase because of high heels. They usually relate that they strike the buttocks often and hard in their rapid descent. Such cases respond slowly to treatment, no matter what it may be. This can be explained by the fact that some of these patients often have an incomplete fracture of the sacrum, which apparently is not uniformly evident in the average anterior-posterior view of the x-ray examination. This statement is borne out by the fact that extensive ecchymotic changes may not appear about the buttocks, thighs or back for from two to four weeks following the initial injury, it being commonly known that ecchymosis is delayed in appearing following fractures covered by dense musculature such as the femur or the pelvis.

(**)Smith, A. Def., *Posterior Dispiacement of the Fifth Lumbar Vertebra*—Jour. Bone and Joint Surgery. XVI—877, October 1934.

(*) Johnson, Robert W. Jr., *Posterior Luxations of the Lumbo-Sacral Joint*—Jour. Bone & Joint Surgery. XVI—867. October 1934.

IV. *Focal Infection* has proven to be an outstanding etiological factor in a large percentage of patients with chronic low back pain. Muscle spasm is a predominant clinical manifestation, especially the long erector spinae group, and to a lesser extent the gluteus medius and quadratus lumborum. Here we meet with old-fashioned lumbago.

In searching for foci, the teeth should be x-rayed in order to detect apical abscess formation, enlarged granulomata or devitalized teeth. Small tonsil tabs are ordinarily overlooked or considered as a harmless remnant, yet they may harbor virulent organisms, as has been proven very often. Chronic post nasal droppings; chronic accessory sinus infections or an occasional repetition of a sore throat, all play an important part in the production of focal infection in the study of this group of chronic backache.

In the male a chronic prostatitis, even though apparently symptomless should be investigated with smears or cultures following prostatic massage. Repeated prostatic massage by the urologist or capable practitioner has rapidly lessened such types of back pain, without resorting to additional mechanical measures. The female cervical discharge or cervical erosion is a very common focus responsible for lumbo-sacral pain. Many such cases are readily relieved of backache following cauterization of an eroded cervix, even though no local treatment is directed for relief of the backache *per se*.

Tumors of the lower levels of the spinal cord may manifest themselves by progressively increasing low back pain. Some of the patients eventually experience lessened sensation along the nerve distribution from the lumbo-sacral region, with gross neurological signs. For example, in tumors of the cauda equina, the patient may experience rather sudden excruciating pain for several days, or sometimes for longer periods, the pain subsequently lessening in degree. Atrophy of the entire lower extremity will gradually be evident, the ankle jerk lessening and finally cannot be elicited.

Malignant metastases of the lower spine may come on very slowly or quite suddenly following even slight jarring, mild back strains, sneezing or coughing. The distribution of pain and spasm varies from the more common types of chronic low back pain, with their persistent aching at the lumbo-sacral region and spasm of the hamstring muscles.

Where there is a chronic inflammatory process in the spinal canal, a new growth or a metastasis, the pain distribution may be rather bizarre, being located quite distant from the seat of disease.

One should suspect malignancy where there is an irregular induration of the skin and its underlying soft tissues, in the region of the lower back, unless there is a recent history of severe local trauma or a dermatitis. It is essential in these patients that thorough x-ray studies be made, well above and below the lumbo-sacral region, including also the pelvis and chest. Enlightened information may be gained from the patients history of previous operations.

The differential diagnosis between lumbo-sacral backache and that due to sacro-iliac pain is intentionally omitted because of the difficulty in being able to accurately distinguish these two conditions. In the majority of such cases in doubt, where no pathology is evident roentgenologically, one can err less often by leaning toward a diagnosis of lumbo-sacral backache, when there is certainty that other less common conditions have been ruled out.

Pain produced by digital pressure of the soft tissues over a sacro-iliac joint is probably due more often to a gluteal myositis or a "fibrositis" (Llewellyn & Jones) than to sacro-iliac pathology.

The treatment of low back pain is of necessity discussed briefly in this comparatively short paper, other than is mentioned under the etiological classification. A patient with a prolonged history of backache must be studied and prescribed for as a clinical entity unto himself or herself.

After the etiological factors are considered the treatment should first be directed at the cause of the spasm of the back muscles, the

cases then being subdivided for convenience into two classes—the simple and the complex mechanical treatment:

1. The simple type in which correction of the mechanical derangement affords ready relief: It is the common practice for a patient to subconsciously have a tilt of the trunk away from the painful side. The following procedure has been successful in a good percentage of this type. With the patient lying face down on the examining table in a relaxed position, radiant heat or dry hot air is administered over the lower back for a period of one half hour or longer. The back is then securely strapped in an over-corrected position, the adhesive strapping extending obliquely on each side from the buttocks to the lower dorsal levels. This treatment is repeated, if necessary, every five days depending upon the tolerance of the patient's skin to adhesive composition. Where the tilt of the trunk is toward the painful side, such patients should rest in bed and receive some form of deep heat therapy several times a day. At best the response to treatment in this type is usually slow.

In anyone with chronic low back pain he or she should sleep on a bed with a flat spring, such as is used in hospitals and in addition joined table leaves are placed transversely between the spring and mattress to avoid undue sagging of the back.

2. The Complex type where there is a flattening or a marked increase of the normal lumbar lordosis, or in those who do not respond to the simpler measures just described, rest in bed should be advised for at least short periods of time. Temporary relief quickly follows the application of Russel traction to one or both sides, to overcome the spasm which so commonly radiates down the thigh posteriorly in a goodly number of these patients. It is best to follow the resulting relaxation with a properly fitting plaster jacket, while the patient is standing, with the trunk bent forward at an angle of about 150°. Back exercises should be commenced two to three days later. Judgment and experience dictate when the plaster jacket may be bi-valved between the third and sixth week, to permit physiotherapy, massage and carefully graded exercises of the back, the gluteii and abdomen, so as to obtain a return of good muscle tone. Development of the latter three sets of muscles is especially indicated in patients with an increased lumbar lordosis.

Should conservative treatment fail to afford prolonged relief in a patient with an unstable fifth lumbar vertebra, operative fixation of the lumbo-sacral region will ultimately become necessary. Of course this would preferably apply to those in the age group between twenty and forty-five, where the patient's condition has been thoroughly studied.

There is a type of low-back pain which resists the commonly accepted forms of treatment. This class of patient is often diagnosed as having a "Sciatic Scolosis" or even a true sciatica with absence of the ankle jerk. A common finding in some of these patients is a very taut ilio tibial band, which when tenotomized affords almost prompt relief from pain. I am personally indebted to Dr. Frank Ober, of Boston, who demonstrated this finding with its subsequent successful operative result.

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PREGNANCY IN THE FIBROMYOMATOUS UTERUS

By William E. Studdiford, M.D., New York City

Read before the Monmouth County Medical Society, November 26, 1934, at Allenhurst.

From the Obstetrical and Gynecological Service, Bellevue Hospital, and the University and Bellevue Hospital Medical College.

Recently I have seen two cases who came to me for examination. One, a young woman of 27, was complaining of menopausal symptoms. She stated that two years previously she had been pregnant and had reached the third month with no unusual symptoms. She had noticed no abdominal mass. At this time she was examined by her physician, who advised an immediate consultation. The consultant agreed that she had a fibromyoma complicating her pregnancy, hospitalized her and performed a supravaginal hysterectomy and bilateral salpingoöphorectomy. The other, a woman of 38, was about three months pregnant and had been advised to have a similar operation because of the presence of several small fibroids. She was told by her physician that the danger of hemorrhage with such a complication was so great that it would be unsafe to allow the pregnancy to go any further. The treatment which was undertaken in the first instance and the advice given in the second seems so at variance with my own ideas that I thought it would be of interest to review the relationship between pregnancy and the fibroid uterus.

FERTILITY

It has long been noted that fibroids have a definite and adverse relationship to fertility. This seems most reasonable when one considers the distortion of the uterus by the intramural and submucous types of tumor. In addition, the presence of these two types of tumors are accompanied by marked changes in the uterine circulation in close proximity to the endometrium. In the case of the submucous tumors, the overlying portions of the endometrium become atrophic and make a poor site for nidation of the ovum. The expulsive contractions of the uterus when a submucous fibroid is present are unfavorable to the occurrence of continuance of pregnancy. Tumors of a subserous type are least liable to interfere with embedding of the ovum and its development. One must always bear in mind, however, that less than 10 per cent of cases have single tumors and that fibroids are usually present in at least two of the three possible locations. Finally, fibroids are frequently accompanied by other lesions, the most common of which is salpingitis. This was found to be present in 27 per cent of a series of 250 uteri removed because of fibromyometa. Graves states that the average incidence of sterility in women in general is 10-15 per cent, while in women with fibroids it rises to 30 per cent. Among two hundred married women operated on for fibromyometa it was found that 37 per cent were either sterile or in a few instances, had an early pregnancy terminating in abortion. This may be used as an argument for myomectomy if a woman with small fibroids fails to become pregnant after a few years of marriage. Before this operation is undertaken, however, one must eliminate any other causes for sterility and it is particularly important to demonstrate the patency of the fallopian tubes.

STERILITY

Conversely, it is felt by many that the failure to become pregnant may favor the development of fibroids. Watson states that the uterus is essentially an active organ, its main activity being the embedding, nourishing and expulsion of the fertilized ovum. If this, its main occupation, is denied, it occupied itself in growing fibroids. About 20 per cent of 250 operated cases were found to be single women, an unusually high incidence in gynecological patients. In the 200 cases of married women, it was found that 37.2 per cent were sterile or had early abortions; 27.6 per cent had had a single child; 14 per cent had had two children; 12 per cent had had three children; 6.5 per cent had had four children; 2 per cent had had five children; one, or .5 per cent had had seven children; and one, or .5 per cent

had had ten children. This last case was operated on at the age of 54 for a large submucous tumor causing menorrhagia. Another case aged 24 with four living children was operated on for a similar tumor. In spite of these exceptions, it is worth noting that 64 per cent were either sterile, had abortions or had only one child. This fact is of importance in the treatment of cases with large fibroids that are successfully carried to term.

INCIDENCE

The reported incidence of fibroids in pregnant women shows considerable variance. Three reports from the Sloane Hospital on this subject have been made. Craigin and Ryder found .45 per cent in the first 20,000 cases delivered. Pierson found .8 per cent in the next 30,000 cases, and Watson, reporting a final group of cases, finds the incidence to be 1.3 per cent. The latter feels that the increase is due to better observation. Another factor may be the increased number of Caesareans performed, for frequently small tumors are noted for the first time at the time that this operation is performed. Certainly the occurrence of large tumors complicating pregnancy must lie well under 1 per cent. This again emphasizes the relationship to sterility, since the incidence of fibroids in general is much higher than 1 per cent, Cullen having found them in approximately 10 per cent of white women, and in 33 per cent of colored.

In the vast majority of cases with fibroids who become pregnant, the tumors are small. On the other hand, pregnancy may occur in the most unpromising cases. Recently a colored patient was seen at Bellevue with a large subserous fibroid rising above the umbilicus who became pregnant after eighteen years of marriage. She aborted following the removal of the largest tumor. In spite of the presence of numerous smaller tumors she became pregnant, went to term and delivered a normal healthy infant within a year of her operation. Several instances have been observed where patients became pregnant and went to term in spite of the presence of large submucous tumors. It is doubtful if anyone can absolutely predict the course of pregnancy in the woman with fibroids. As a rule it is surprising how the abdomen accommodates itself to a pregnancy in addition to a large tumor. Fibroids during pregnancy become more easily felt because the surrounding uterine wall becomes thin and soft and the muscle cells of the tumor undergo hypertrophy, causing actual enlargement. Involution takes place post partum.

ABORTION

The woman with fibroids who becomes pregnant shows a definite tendency to abort or to go into premature labor. In the 157 cases reviewed by Watson, 71 early or late abortions occurred and 24 went into premature labor. Only 40 per cent carried on to term. The incidence of abortion and premature labor in the normal pregnant woman is said to be 20 per cent so that the risk of this occurrence is approximately tripled. The repeated occurrence of this accident is an indication for myomectomy, an operation which should be performed when the mother is not pregnant. When performed on the pregnant woman it simply increases the risk of abortion or premature labor, which is already great. It should not be done simply because the patient has aborted once, since such patients may carry the next pregnancy on to term. Two such cases were seen in September, 1933. Both aborted in October at the third month. Both became pregnant again in January, 1934, and both are now mothers of healthy children, although one developed a severe preëclamptic toxemia and delivered about four weeks before term. This tendency to abortion and premature labor makes it imperative for the mother to take much more rest in the antepartum period than the average pregnant woman. It is wise to warn such patients that long periods of bed rest may be necessary if they are to have a living child. In addition to the danger of early termination of the pregnancy, a frequent complication, particularly in the last half of pregnancy, is the onset of acute degeneration in the fibroid. This is signalized by the onset of pain in the offending tumor and the presence of a low fever and moderate leucocytosis. Watson reports its presence in twenty-three of

forty-one cases in which hysterectomy or myomectomy were done, while Eisaman recently reports an incidence of 69 per cent in cases of pregnancy complicated by fibroids. Campbell states that it is found ten times more frequently in specimens removed during pregnancy than in those removed in the nonpregnant state. The frequency with which this occurs during pregnancy can be explained by the peculiar blood supply of fibroids and the marked change of position that they undergo during pregnancy. Cases developing this complication can almost always be carried along by complete rest in bed. Ice bags over the offending tumor and sedatives almost always give complete relief. The acute symptoms disappear in ten days to two weeks. The subsequent changes of necrosis and sometimes of liquefaction may take place before term is reached and are frequently found in specimens removed at Caesarean section. Rarely the acuteness of the symptoms and the additional presence of distention, nausea and vomiting make operation necessary. These then are the risks to the patient during the antepartum period. They are undoubtedly greater than those run by the average pregnant woman but they are certainly not too great if she is kept under careful observation. They do not justify terminating an early pregnancy if the woman is anxious to have children.

LABOR

Women who reach term with small uterine fibroids as a rule show no abnormality in labor. Those with larger tumors rarely have difficulty with actual obstruction because of the tumor. Most uterine fibroids are situated in the corpus and are lifted out of the pelvis with the enlarging pregnant uterus. Uncommonly, actual obstruction may be offered by a subserous fibroid which is adherent in the cul-de-sac or by a cervical tumor. Difficulties may be encountered because the presence of fibroids seems to cause faulty uterine contractions. This, however, is not absolutely to be expected, and often rapid normal labors occur. Postpartum hemorrhage may occur for the same reason. Occasionally the placenta is adherent, requiring manual removal. This usually occurs in the presence of a submucous fibroid. In the 157 cases reported by Watson there were seventy-one operative or breech deliveries, including twenty-three forceps operations, four versions, thirty-five Cesareans and nine breech extractions. Only fifteen of the Cesareans were done primarily because of fibroids. There were two intrauterine deaths and eighteen still births. Only one deformed child was noted. One case of placenta previa was encountered and three of postpartum hemorrhage. Only one maternal death occurred in which the presence of fibroids could be a factor. From the above statements it must be granted that fibroids are a major complication of pregnancy. Nevertheless it must again be repeated that the risk is not too great, providing the patient is properly observed during pregnancy and cared for during labor. Certain cases in which the fibroids are large and in which one may expect complications in the puerperium and symptoms in later life can be most advantageously treated by Cesarean section and hysterectomy at term. These patients are usually elderly. Occasionally if the fibroids are remote from the uterine cavity and from the uterine incision myomectomy may be done. Under other circumstances it may lead to serious results. One must always remember that under the best of circumstances myomectomy is accompanied by a more stormy convalescence than hysterectomy.

In cases delivered by the vaginal route it is not uncommon to see acute degenerative changes arise in one or more tumors early in the postpartum period. As noted before, this change is accompanied by low fever and leucocytosis but is more dangerous because of the possibility of secondary infection. If the symptoms are not marked and one can feel sure that the offending fibroid is remote from the uterine cavity, this complication can be treated conservatively. If the pain is marked and the fever high, particularly if the tumor is intramural or submucous, immediate hysterectomy should be performed.

SUMMARY

1. Fibroids are a large factor in sterility. Certain selected cases may benefit from myo-

mectomy, carrying subsequent pregnancies through to term.

2. Fibroids are a large factor in abortion and premature labor. Certain cases in which such accidents have repeatedly occurred may be benefitted by myomectomy and subsequently carry pregnancy through to term.

3. The chief dangers to cases with fibroids during the antepartum period is that of early interruption of the pregnancy, and the onset of acute degenerative changes in the tumors.

4. The necessity for operative intervention because of degenerative changes in fibroids during pregnancy is rare.

5. Cases with small fibroids, if carried to term, often go through a normal labor.

6. Cases with large fibroids, usually in elderly women, are best treated with Cesarean section and hysterectomy if carried to term. These patients are fortunate to have reached term and are not likely to carry another pregnancy this far. A living child is therefore more important than in the average woman. The risks of vaginal delivery are great. There is an excellent possibility of acute degenerative changes beginning in the puerperium necessitating operation. Furthermore, they are likely to require surgical treatment for the fibroids within a few years. In a few instances Cesarean section and myomectomy may prove practical.

7. Finally, certain cases delivered by the vaginal route may develop acute degenerative changes in the puerperium requiring surgical intervention at this time.

AN ANALYSIS OF 3344 OPERATIONS FOR APPENDICITIS WITH REMARKS ON THE DELAYED OPERATION IN DELAYED CASES OF APPENDICITIS

By WILLIAM D. HAGGARD, M.D., F.A.C.S., D.C.L.,
President, American College Surgeons; Professor of Clinical Surgery, Vanderbilt University School of Medicine, Nashville, Tennessee

Abstract of paper presented before the Atlantic County Medical Society, October 12th, 1934

This study embraces an operative experience of 3344 cases.

In 1915, 1133 operations were reported with a mortality of 2.5 per cent. Since then 2211 appendix operations were performed up to September 1, 1934, with a mortality of 3.39 per cent.

Of these, 1650 were acute, unruptured, subacute and recurrent, 672 being acute, and 225 operated upon in the first 24 hours, the mortality being 0.72 per cent. Of these only 120 were chronic.

In 379 ruptured cases the mortality was 5 per cent. The average duration was 5 1/3 days. In 186 cases of gangrene, perforation, and generalized spreading peritonitis the mortality was 24.7 per cent, the average period before operation being 2¼ days, 34 having a period beyond 3½ days, and one case of secondary peritonitis from a walled-in abscess went 17 days before operation.

In 871 cases the appendectomy was incidental to other intraäbdominal operations with a mortality of 2.2 per cent.

The annual death rate from appendicitis in England and Wales is 7; in France 3, and in the United States is over 17 per hundred thousand; and so that it is estimated that 20,000 die from appendicitis annually in the United States.

MORTALITY RATES

Although our knowledge of appendicitis dates from the epoch-marking paper of Fitz in 1886, the surgical management of appendicitis has not improved as it should, since the mortality rate is practically as high as it was twenty years ago.

The problem is of great economic importance, since the average age of those dying from appendicitis is 32, the most productive period of life, contrasted with the diseases of older life such as cancer, heart disease, and nephritis.

In 1932, one of the large insurance companies paid out over three-quarters of a billion dollars in death benefits for appendicitis alone.

The three essential prerequisites for improvement in this situation are:

Early hospitalization;

The prevention of the administration of laxatives in acute abdominal cases; and

Efforts directed toward the reduction of the mortality from spreading peritonitis.

In Philadelphia, as a result of a campaign directed toward these ends, the mortality of spreading appendicitis in three years was reduced 9.5 per cent and of local peritonitis 2.7 per cent. The Philadelphia County Medical Society furnishes stickers to all its members to be attached to their monthly statements which aid in the dissemination of information and which read as follows:

"Warning!
In the Presence of Abdominal Pain
Never Give a *Laxative*
Give Nothing by Mouth
Apply Ice or *Hot* Water Bottle
Call Your Family Physician."

DIAGNOSIS

Early diagnosis is, of course, of great importance. It is valuable to recall that the symptoms occur in pairs: pain and vomiting; tenderness and rigidity; fever and leukocytosis; although there may be wide variation in their appearance and intensity.

Pain is always present, and tenderness uniformly present (absent in 11 per cent). Leukocytosis, absent in 20 per cent, is the one corroborative test.

Sudden cessation of pain, especially when all other symptoms continue, indicates *gangrene.*

Sudden cessation of severe pain suggests *perforation.*

This is usually the lull before the storm—peritonitis. Continuous, persistent vomiting usually means some complication: perforation, gangrene, peritonitis, or obstruction.

Rigidity is valuable and often corresponds to the point of greatest tenderness.

Chill nearly always means gangrene.

Very high temperature suggests some lesion other than the appendix, and especially when it precedes the pain.

The diagnosis is difficult in children as they cannot describe their symptoms well. Perforation is more frequent in children, and may occur before the preceding condition is recognized. Tenderness and rigidity are the most dependable signs. The abdominal pain in right pleuropneumonia is familiar and makes the diagnosis of great import.

Hydrorrhea from pressure on the rectum with a discharge of mucous suggests pelvic abscess from appendicitis. The anus is patulous.

The two important types of appendicitis are the interstitial, where the inflammation is in the wall; and the acute obstructive, usually at the base and often with an enterolith. The latter often becomes gangrenous from interference with the circulation as well as obstruction of the lumen.

The obstruction type causes most of the deaths and emphasizes the futility of administering purgatives in abdominal colic.

TIME FOR OPERATING

No case of appendicitis is too mild for operation. It is often regretted that a patient was operated upon too late; never that operation was too soon.

All suspected cases should be hospitalized for at least thorough study.

It is hard to say which is worse: purgative treatment early; or surgical treatment late. When the early, safe period for operation has been frittered away, then conservative treatment is at times most judicious; but in the majority of cases when a purgative has been given, there is no conservative treatment, operation is imperative.

The surgeon should refrain from removing an appendix not easily found in an old walled-off abscess, since to dig it out may scatter the infection.

If one starts out on the Ochsner plan of non-interference because the patient has come too late for early operation and too early for later operation, he should not change horses in the middle of the stream.

On account of the notoriously high mortal-

ity in the third and fourth day cases, Ochsner taught that such cases were better delayed than to have an operation at a period before nature had been able to do her share in the protection of the patient. All of the older surgeons saw many severe cases which had undergone resolution. Now no severe case is permitted to undergo resolution. The more severe the case, the more certain is it to have operation and the higher the death-rate. No case must die without "benefit of clergy". The older surgeons noticed that many of these patients would get well although they left the hospital with a lump in their sides. Every practitioner has seen many cases of abscess of the appendix and all surgeons have had a uniformly good result where the abscess had become well localized and was operated on anywhere from the tenth to the fourteenth day. If, by good fortune, the abscess was adherent to the abdominal wall, which simply required incision and evacuation, they practically all got well.

Dr. Haggard concluded his survey with these dicta:

"In order to reduce the unwarranted and unnecessary mortality in appendicitis, we must:

(I) Operate upon it in the early hours of the disease, even though it might be regarded as a mild attack;

(II) Teach families to avoid purgatives in every case of abdominal pain;

(III) Consider each case individually. Do complete laboratory work and give adequate preparatory treatment rather than follow an iron-clad rule to operate on delayed cases of appendicitis irrespective of the patient's condition as a hurried midnight emergency operation;

(IV) Remember the emergency is in the first few hours;

(V) In many instances, delay in delayed cases of appendicitis as the part of surgical wisdom.

DISCUSSION

The discussion of Dr. Haggard's paper was opened by Dr. Edward Klopp, Professor of Clinical Surgery, Jefferson Medical College, Philadelphia, Pa., a summary of whose remarks follows:

I have collected 200 cases of appendicitis spreading over my service of four years at Jefferson. All were ward cases—none private, since if a surgeon collects statistics on his private cases, he will find them much better than those on the ward cases. Those are the patients who come from the lower walks of life, and whose conditions not of the best. Then too, these are frequently left to the interne to operate upon. If one studies the statistics, it is questionable whether an intern should be allowed to operate on the gangrenous appendix or peritonitis patient.

Here Dr. Klopp showed three lantern slides showing statistics of three age groups of patients—from 1 to 20, 20 to 40, and over 40.

These slides showed the relation of time of onset to the time of operation; and after three days had elapsed, very few operations were performed except in the cases of abscess of the appendix. They also showed that laxatives were conducive to perforation and abscess. Higher temperatures were encountered in abscess formation. The leukocyte count changes with the course of the disease. The highest mortality was found in acute perforations.

The charts showed that abscess is far safer than acute spreading peritonitis.

Judgment as to the time of operation is more necessary than surgical dexterity. This has more to do with success than the manipulations or the mechanic who does the operating.

The anatomical disposition of the appendix is very important. Certain appendices will not become diseased. Others because of kinking, or of adhesions, may become diseased. Others again because of location: the pelvic appendix. After the colon comes to the subhepatic region and then descends, sometimes it goes too far. Sometimes it goes down into the pelvis and disease of this appendix is very difficult to diagnose and there are more deaths from this than from all others combined. How many doctors have sat by their children with pelvic appendicitis and let them go on to peritonitis unrecognized? The symptoms do not always conform to the schedule.

We should make an early diagnosis and recommend an early operation.

I do not believe that all the statistics as published are due entirely to laxatives, lack of judgment, or rough manipulation at the time of operation. I believe a lot depends on the bacteria present in peritonitis at the time of operation and the attempt to wall off the appendix when rupture is imminent. Some are operated on six hours after onset and the appendix is found ruptured and an early spreading peritonitis is present. Bacteriological studies reveal two or three organisms—colon, streptococcus, etc.—and how can we operate earlier than six hours atfer the onset of symptoms?

We cannot dwell too strongly on the abuse of laxatives. Some of my patients have had as many as four, taking one after the other.

It has been our custom—and until we have better information we shall continue to do so—to follow a plan something like this: Each case of acute appendicitis seen within 36 hours after onset (with few exceptions) should be operated on immediately. From 36 to 72 hours it is sometimes more difficult to decide on immediate operation. The slides showed very definitely that after 72 hours the patient is

comparatively safe without peritonitis spreading; and he then has a chance to go on to the time when he can be operated on. I believe we are called upon to use our very best jugdment during the period from 36 to 72 hours.

General Discussion

Dr. H. I. Silvers: It seems to me that tonight it is for us to listen rather than to enter into any discussion.

There is no question that an abscess when walled off is safer if not too much operating is done. There is grave danger if there is too much manipulation after the third day, or even after 48 hours. This is a very critical time for the patient. It requires courage to wait; and for that particular reason I am indebted to Dr. Haggard for his portrayal tonight.

Dr. T. Senseman: The question of 24, 48, 72 hours, or one week, has nothing to do in my mind with the indication for operating in appendicitis. The only indication for not operating is spreading peritonitis. The technic and experience of the operator has everything to do with it. If you find a gangrenous appendix, I see no reason that it should not be taken out, providing the surgeon is able with his sense of touch to recognize a line of cleavage and stick to it and wall off the area with gauze.

Two important principles in treating acute gangrenous appendicitis, and in fact, in all abdominal surgery, are:

1. To get in; and get out. Not see how much you can do and get away with, but how little you can do and accomplish the purpose aimed at.
2. Adequate and proper drainage spells the difference between mortality and recovery.

The only way to insert drainage is to put it below the cecum, pull the intestines back, and let it go down over the brim of the pelvis into the cul-de-sac—the cesspool of the lower abdomen. The object of abdominal drainage is to drain the cesspools. I never use anything but cigarette drainage. It is softest, and utilizes the principle of osmosis. I believe secondary abscesses are due to faulty, inadequate or improper drainage.

Dr. V. E. Johnson: Personally, I think one should accept the figures as given here tonight by both Dr. Haggard and Dr. Klopp. About the question of the third day, we must recognize that at that time we come in contact with three types: 1, those getting well; 2, those already forming their abscess, and 3, those who are very sick. To a great extent there are a number of those cases upon which we cannot delay operating. On the other hand, there are so many so toxic that it would be very foolish to operate. Judgment must be used about when to operate. So far as technic goes, the experience of the man doing the operation certainly has a great deal to do with whether the patient will get well or not.

Dr. W. E. Darnall: We cannot put these cases in an iron-clad class. While in a general way time counts, every patient who comes to us is an individual study in himself. One cannot say that every patient that comes along is in this class or that. They are individual studies. I do believe there is a time when one should not operate, and there is a time when it takes our best judgment, study, and experience to determine whether we should operate or not. I think also that much or some of the high mortality is due to the fact that when the average surgeon sees a case of appendicitis, he is inclined to operate immediately, not using his judgment to determine whether it is in the period of intermission It it not always the surgeon's fault. Pressure is brought to bear on him. He is in an embarrassing position, and is expected to do something. It cannot be made a routine matter according to the day or hour of illness, but each case must be studied individually.

Dr. Myatt: I recently had a patient with a generalized peritonitis; the leukocyte count was only 5000; and two rubber dam drains were used. For four days the patient went along fine and then developed an acute psychosis. He was hard to manage in every way. Now the condition is very good. I could not figure out with that count how he could have resistance enough to fight the battle. The time of operation is an individual thing, there can be no cut and dried rule.

Dr. D. B. Allman: The more I see of appendicitis, the less I know about it. It seems better to use our past experience as our guide and throw the books away. The subject of delaying appendix operations has not been given much thought by the surgeons of today because we have been raised in the environment of appendicitis. We should not operate against our better judgment, but the public must be quickly educated to the fact that every appendix should not come out the minute the surgeon sees it. This fact is impressed upon us by the change in the treatment of head cases—a few years ago eight out of ten cases of head injury were decompressed as soon as we could do it. If they got well, it was all right; and if they died, it was an act of God. Now we know that the treatment is most radically changed. We should not fear such criticism, for the public must and can be educated. Everybody has his own idea. You must see each case with its history and let your experience make your decision whether you will operate now, tomorrow, or not at all.

Dr. Haggard: Patients sick less than 72 hours are more readily operated upon with safety. Of course, one cannot set a time clock, but must use judgment. The general practitioner has the best chance where he also does his own operations; but when the consultant comes into the picture, there is sometimes difficulty.

The thing of importance is to refrain from doing too much. We must not forget nature. She will take care of certain types of cases. It is up to us to discriminate between the very desperate cases.

We must all depend upon our judgment, and the accumulated knowledge we have. We have not quite gotten to the wisdom of deferring operations and letting nature do its work.

HEAD INJURIES, TREATMENT AND EVALUATION

By S. Bernard Wortis, M.D.,
Assistant Professor of Neurology, New York University
Abstract of an Address before the Hudson County Medical Society, October 2, 1934

In recent years the acute and remote symptoms of head injuries have become matters of medical, sociological and economic importance. Law courts and compensation courts are indeed filled with such problems, and it often becomes the duty of the attending physician to advise the court in matters of symptom evaluation and disability appraisal.

CASES IN BELLEVUE HOSPITAL

At Bellevue Hospital we have reviewed 1000 cases of acute head injury having one or more of the following diagnostic criteria:

a. Post mortem findings of skull fracture or brain laceration.

b. Positive Roentgen evidence of skull fracture.

c. Bloody spinal fluid obtained by lumbar puncture.

In this group of cases the following facts were noted:

1. The mortality rate averaged 37.8 per cent, being lower in children under 12 years of age (i. e. 25.8 per cent) and higher in adults over 60 years of age (i. e. 49.6 per cent).

2. Automobile accidents and falls were the most common causes of severe head injuries.

3. X-rays taken in 499 cases were negative in 230; 63 showed fractures of the base; 186 revealed linear vault fractures, and 20 had depressed vault fractures.

4. Lumbar puncture was done in 846 patients, of which 801 had bloody spinal fluid. In only 45 of the 1000 patients was the spinal fluid clear. The mortality rate was three times greater in patients having bloody spinal fluid associated with "long" periods of unconsciousness (i. e. over three hours).

5. Autopsies performed in 257 of the 378 patients (in the series of 1000 cases) who died showed gross brain laceration in 91.8 per cent, brain abscess in only two cases and suppurative meningitis in only fourteen cases.

6. Bleeding from the ears, nose, mouth or about the eyes occurred in 701 patients.

7. Eight hundred nineteen of the 1000 patients showed evidence of central nervous system injury on clinical neurological examination. Ten per cent of the patients had papilledema (mild or moderate in degree) resulting from their head injury. Three per cent had retinal hemorrhages.

8. Ten per cent of the group had peripheral facial paralysis following the trauma.

9 Generalized convulsions occurred in 78 patients and 34 had focal convulsions.

10. Of the 378 fatal cases it was found that 53 per cent of these died within their first 24 hours in the hospital.

TREATMENT

The following standardized regime for the treatment of acute head injuries is recommended:

1. Shock should be treated with intravenous injections of hypertonic glucose solution: 10 cc. to 500 cc. of 50 per cent sterile dextrose.

2. Lumbar puncture should be done with the removal of a small amount of fluid to determine the presence or absence of red blood cells. This procedure is valuable in order to determine how long the patient should remain convalescent. Where blood is found, I have found it wise to keep the patient in bed for at least 4 to 6 weeks. If the cerebrospinal fluid is clear, the patient may be allowed up much sooner.

3. Caffeine sodiobenzoate should be given by hypodermic injection (5 or 7½ grains) three times daily. This drug reduces intracranial pressure—very likely because of its diuretic effect—and is a valuable adjunct to therapy.

4. Restrict water intake below 1000 cc. daily for at least 4 to 8 weeks or longer, following severe head injury.

5. The head of the bed should be elevated

from 15 to 45 degrees after the stage of shock is passed. This also helps reduce intracranial pressure.

6. Operative procedures are necessary in compound fractures requiring debridement and in cases of suspected middle meningeal hemorrhage. When epidural hemorrhage is suspected, this can be confirmed by looking into the skull through a small trephine hole, before subjecting the patient to an extensive bone flap operation. Occasionally the bleeding point is in the opposite side of the skull from where the clinical signs point.

7. Uncomplicated depressed vault fractures may be elevated after the passage of acute shock. In such instances it is often better to postpone surgical procedures a few days.

8. *All cases* of head injury are helped much by phenolbarbital grs. ¼ B.I.D. or T.I.D.—or other mild sedative medication—extended during the convalescent peirod for at least 4 to 6 months from the time of injury.

EVALUATION OF SYMPTOMS AND APPRAISAL OF DISABILITY

Only a small percentage of head injuries of all types return to the hospital later with any complaints. The physician must try to harmonize the degree of alleged disability with the known injury and the clinical symptoms. It is now known that brain laceration with subarachnoid hemorrhage or severe head contusions resulting in multiple miliary brain hemorrhages may later end in brain scarring with distortion of the ventricular system. Not infrequently adhesions between the lacerated brain area and the adjacent meninges results in post traumatic convulsions or epileptic equivalents with behavior changes. On the other hand, people who sustain injuries of a minor nature may become hysterical or for purposes of gain may simulate disease. It becomes the duty of the physician to distinguish disability dependent upon brain tissue destruction from disability which is of hysterical origin and from malingering.

The following plan is offered to help determine the degree of disability dependent upon structural neural injury:

a. Absolute criteria of brain injury
   1. Roentgen evidence of skull fracture
   2. Bloody spinal fluid
   3. Bleeding or cerebrospinal fluid leakage from the orifices (especially from the ears)
   4. Focal cerebral palsies

b. Presumptive criteria of brain injury
   5. Convulsive states—proved post-traumatic
   6. Ventricular distortion—proved post-traumatic
   7. History of prolonged unconsciousness
   8. History of adequate trauma

Most patients who have had head injuries complain later of headaches and dizziness; these are best treated with sedative medication. A patient complaining of such symptoms after head injury who has had *none* of the absolute or presumptive criteria—and who in addition shows the bizarre sensory aberration in the clinical neurological tests—should be viewed with the suspicion that he may well be a case of hysteria or malingering. Encephalography should be performed in all post traumatic head cases where symptoms persist more than one year.

Post-traumatic neuroses are enhanced and often indelibly written into the patient by much hospitalization, examination, litigation and unjustified periodic compensation. All cases of head injury, especially those patients suffering with post-traumatic neurotic symptoms, are best treated medically and sociologically by prompt accurate diagnosis and treatment, speedy adjudication and economic *final* adjustment in a single settlement whenever possible.

STATE SOCIETY ACTIVITIES

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By John F. Hagerty, M.D., Newark, N. J.,
Chairman of the New Jersey Delegation

It may be confidently stated that the recent meeting of the American Medical Association was an unqualified success. Indeed, it was probably the most successful convention ever held, exceeding in point of numbers and the size and value of the scientific and commercial exhibits all other meetings, while the presence of the Canadian Medical Association was an added feature, increasing greatly the interest and enjoyment of the meeting.

Atlantic City upheld its claim to be a most desirable city for such large gatherings, by providing splendid hotel accommodations and the conveniently located Auditorium, adequate for housing the exhibits and all of the scientific meetings, together with the attractive boardwalk with its glorious view of the ocean and the stimulating effects of sunshine, which, happily, was present during all but the first day of the Convention.

The sessions of the House of Delegates were well attended, 159 of 175 delegates being present; and while the amount of new business introduced was small compared with other meetings, great interest was shown in many of the problems; and the visit of the members of the Canadian Medical Council at the Tuesday morning session and their felicitous replies to the welcoming address of our officials were highly enjoyable incidents of the meeting.

In compliance with the repeated requests of the Speaker of the House that component societies be informed by the delegates of the work of the Association, of the Officers and Trustees and Councils, an effort will be made to portray some of the work done and results accomplished last year.

Some idea of the labor and time-consuming effort involved in the office of President may be had by stating that Dr. Biering traveled 67,000 miles, visiting every State and many County Societies in different States. Dr. Biering had been a general practitioner, has always been more interested in medicine than surgery, has long been interested in promoting the standards of medical education and outspoken in his opposition to socialized medicine, and being a fluent, graceful and forceful speaker, has proved to be a valuable aid to organized medicine during the past two years.

It is pleasing to note from the Secretary's report that the number of Members and Fellows of the Association is greater than that of one year ago. The number of Members is almost 100,000.

The report of the Board of Trustees states:

"The demands made on the various councils, bureaus, and departments of the Association, and the amount of business transacted by the Board of Trustees and other official bodies were far greater during the last year than in any previous year. At no time in the history of the Association have there been matters of more transcendent importance presented for official consideration and action at the hands of the various official bodies that carry on the work of the Association. In some instances, existing facilities in the Association's offices have been taxed to the utmost, and the situation has been one that has called for extreme exertion on the part of the administrative personnel and for well-considered action on the part of the officers, councils, bureaus and members of official groups.

"As will be seen from the Auditor's Report, total general operating expenses, including depreciation, amounted to the sum of $825,781.09 for the year covered by this report, as compared with $836,954.04 in the preceding year. Association expenses, including the cost of operation of councils, bureaus, and departments and of miscellaneous operations, were $350,297.48 in 1934, as compared with $333,730.40 in 1933. The increased expenditures in 1934 were occasioned by the expansion of the work of various councils and bureaus.

"The total operating income for 1934 was $1,439,751.07 as compared with $1,375,337.99 for the previous year. Interest reecived from investments amounted to $82,402.41,—almost exactly $5,000 more than income from this source in 1933.

"The Journal continued during 1934 the developments begun in previous years. Today it is everywhere recognized as the leading medical publication of the world, and as the official voice of the American medical profession. It has kept its readers abreast of developments

in the field of legislation, and it has spoken promptly for scientific medicine when the tenets and principles of the profession seemed about to be subjected to assault."

In addition, the Board is responsible for the publication of special journals: viz. Hygeia, Archives of Surgery, Archives of Internal Medicine, etc.; of the library and package library service; of the Quarterly Cumulative Index Medicus; of the American Medical Directory, and the Coöperative Medical Advertising Bureau. It also supervises the work of the Council on Pharmacy and Chemistry, which has been carrying on this work thirty years, and under which there are Committees on Scientific and Therapeutic Research which encourages scientific investigation in the fields of physiology, chemistry, and therapeutics. The scope of the Council has extended to improved methods of teaching materia medica, to the evaluation of new drugs which the physician has been importuned to use, to the education of the profession concerning newer advances in medicine, and to safeguarding public health by bringing forcibly to the attention of the profession, of the public, and of legislative bodies the need for corrective measures. For the investigations in chemistry and therapeutics, grants are made by the Council to colleges and individual workers amounting to about $20,000 each year.

The Trustees also exercise supervision over the Council on Physical Therapy; the Bureau of Medical Economics, which has investigated during the past few years the cost of medical care, sickness insurance, group hospitalization, contract practice and the like; also the Bureau of Legal Medicine and Legislation, which embraces studies on health insurance, Emergency Relief Administration, Federal food, drug and cosmetic legislation, and narcotic legislation; Bureau of Health and Public Instruction; Bureau of Investigation, etc., etc.

Consideration of these activities will give some idea of the magnitude of the work done by the Board of Trustees. Five meetings of the Board were held last year, each lasting from two to six days. And as proof of the interest of the Board, through its various subcommittees, in promoting scientific research, raising the standards of medicine and studying the welfare of the profession, it might be stated that $350,000 was spent last year investigating and assisting the Councils on Health and Public Instruction, Pharmacy, and Chemistry, Medical Education and Hospitals, Bureau of Medical Economics, and others.

The investigation of Medical Colleges, which has been conducted by the Council on Medical Education during the past year and will be continued another year, will be the most thorough and painstaking ever made, and may result in important regulations governing the number of medical schools and graduates.

The above information is presented so as to inform the profession of some of the activities of the governing bodies of the Association in its behalf and that of the public.

Besides studying and passing judgment on recommendations contained in reports of the Trustees, Councils, and other Standing Committees, some of the specific matters considered by the House were the report of the Judicial Council upon the qualifications for membership and fellowship; and clarifying the subject of Medical Ethics. The results of these deliberations will be published later. Also, the Council on Medical Education urged staffs of hospitals to assist in the education of internes.

Resolutions concerning birth control and contraceptive measures were presented from several State Societies, asking that the House appoint a committee to investigate the use of various contraceptive measures and their effects. Such a committee was formed to study the question one year and report at the next meeting of the House.

The resolution of the Trustees of The Medical Society of New Jersey opposing the Copeland Pure Food and Drug Act, Senate No. 5, and another requesting the Journal of the A. M. A. to refuse advertisements of drug houses that advertise in lay journals and papers, were presented to the A. M. A. House of Delegates; and after their consideration by the Committee on Public Legislation, they were referred to the Board of Trustees.

Dr. James S. McLester, Alabama, was elected President of the Association for the ensuing year, and Dr. J. Tate Mason was elected President-Elect.

Dr. Frederick Warnshuis, who has been the very efficient Speaker of the House fourteen years, was succeeded by Dr. N. B. Van Etten, of New York.

Drs. Pettit, of Oregon, and Upham, of Ohio, were retired as Trustees, and were succeeded by Drs. Fenton, of Oregon, and Bloss, of West Virginia.

Kansas City was chosen for the Convention of 1936.

Respectfully submitted,

John S. Hagerty,
Walt P. Conaway,
E. R. Mulford,
A. Haines Lippincott,
Delegates.

ANNUAL REPORT OF THE TREASURER OF THE MEDICAL SOCIETY OF NEW JERSEY, AT THE END OF THE FISCAL YEAR, June 30, 1935

PERMANENT FUND

DR.

May 31, 1934—	
2 M 1st Liberty Loan 3½% bonds	$2000.00
2 M 4th Liberty Loan 4¼% bonds	2000.00
2 M U. S. Treasury 3¼% bonds of 1943-5	1997.50
Mortgage Certificates, Investors Title & Mortgage Guarantee Co.	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Co.	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
Deposit in Savings Account	17.50
June 13—	
Profit on sale of 2 M 4th L. L. bonds	50.25
	$15,065.25

CR.

May 31, 1935—	
2 M U. S. Treasury 3¼% bonds of 1943-5	$1997.50
1 M U. S. Treasury 3¼% bonds of 1944-6	1034.38
1 M U. S. Treasury 3% bonds of 1946-8	1014.06
Mortgage Certificates, Investors Title & Mortgage Guarantee Co.	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Co.	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
Deposit in Savings Account	2019.31
	$15,065.25

GENERAL ACCOUNT

RECEIPTS

Balance, May 31, 1934		$30,145.04
Assessment:		
Atlantic	$ 1,651	
Bergen	3,016	
Burlington	702	
Camden	2,041	
Cape May	338	
Cumberland	663	
Essex	10,244	
Gloucester	507	
Hudson	4,979	
Hunterdon	338	
Mercer	2,301	
Middlesex	1,638	
Monmouth	1,492	
Morris	1,248	
Ocean	247	
Passaic	3,155	
Salem	221	
Somerset	767	
Sussex	299	
Union	3,687	
Warren	403	
		39,937.00
Publication receipts		7,423.68
Interest		554.33
Miscellaneous		21.00
		$78,081.05

PAYMENTS

For Publication Committee		$12,280.81
" Salaries:		
Secretary	$1500.00	
Executive Officer	6000.00	
Editor	5000.00	
		12,500.00
" Office:		
Clerical services	$3510.00	
Operating expenses	1106.81	
Furniture and equipment	897.52	
Travel	777.33	
Rent	960.00	
		7,251.66
" Expenses of Officers:		
President	$1271.34	
Secretary	1420.72	
Treasurer	60.12	
		2,752.18
" Expenses of Committees:		
Trustees	$ 119.16	
Welfare	90.38	
Public Health	438.61	
E. R. A.	53.30	
Other committees	76.25	
		777.70
" Annual Meeting, 1934:		
Program and arrangements	$ 557.62	
Credentials	248.77	
Scientific Exhibit	152.61	
Guests	249.46	
Woman's Auxiliary	220.70	
Arts and Hobby Committee	70.05	
		1,499.21
" Printing and stationery		2,776.80
" Legal services and expenses		2,063.02
" Cabinets for Scientific Exhibit		300.00
" Woman's Auxiliary		254.50
" A. M. A. RR. fares		75.83
" Professional conferences		50.00
" Miscellaneous		160.90
Transferred to office cash fund		200.00
Balance, May 31, 1935		35,138.44
		$78,081.05

BUDGET RECONCILIATION

Expected income	$47,000.00
Actual receipts	47,936.01
Budget appropriations	44,410.00
Expenditures	42,942.61
Operating net balance	4,993.40

Respectfully submitted,

E. J. Marsh, Treasurer.

THE NEW JERSEY EXHIBIT AT THE A. M. A.



The Exhibit of The Medical Society of New Jersey at the Annual Meeting of the American Medical Association, June 11-15, 1935.

Every State Medical Society has an individuality of its own which becomes apparent when it is compared with the societies of other states. A great object of the Annual Meeting of the American Medical Association is to afford the opportunity for individual doctors and organizations to demonstrate their own activities and set forth their ideals and accomplishments.

The Trustees of The Medical Society of New Jersey authorized the preparation of an exhibit to be shown at the meetings of both the State Society and the American Medical Association. The exhibit was modest in its simplicity, but far-reaching in its implications. Its essential feature was a series of wall charts showing the Society's organization and methods for carrying out its specific projects. Accessory to the charts were reprints describing the peculiar features of New Jersey's aspirations and accomplishments.

An essential feature of every successful exhibit at the A. M. A. was the presence of demonstrators. No exhibit attracted marked attention unless a demonstrator was present to explain what the exhibit stood for. It was physically impossible for one exhibitor to be present during every hour of the five days of the exhibit; but either the Executive Secretary or the Editor—usually both—was constantly in attendance, and seldom lacked an appreciative inquirer during every moment of the time.

The charts and other features of New Jersey's exhibit were designed as texts for impromptu explanations by the demonstrators. The usual course of events was that a physician would pause a moment in his stroll among the exhibit booths. This was the cue for a demonstrator to approach the doctor and inquire what feature interested him. Very often he would point to a chart and ask for its explanation. Usually the visitor sat down and gave his undivided attention to the demonstrator.

The chart that excited the greatest interest was that of the *Public Health Hour,* with that

of the *Emergency Relief Administration* a close second. Every chart was a road map to be studied. A road map of New Jersey that formed a part of the exhibit was frequently consulted by those who wished to orient themselves in regard to the position of Atlantic City and its relation to Philadelphia and New York and other centers. In the same way the charts of the Public Health Hour and the E. R. A. showed the ways to definite objectives. The demonstrators pointed out the routes which were available in the Society's activities, the difficulties encountered, and the results attained.

The exhibit was also the center where the leaders of the Medical Society dropped in for rest or appointments, thereby meeting the visitors and observing their interest in the Society.

The extent and influence of the contacts afforded by the exhibit could not be set forth statistically. They were undoubtedly far greater than would have been those of a speaker announced to deliver a formal address at a section meeting. Every visitor was an audience of one intent on the conversational demonstration, because he could get exactly the information which he sought.

An example of the results was that of a visitor who listened intently without any great show of response. But in the afternoon he brought the President of his State Society who asked pointed questions; and on the following morning he brought another officer of his State Society. It is certain that the officers of that State Society will look to The Medical Society of New Jersey for further evidence of the development of its work. This experience was typical of many during the week.

Many requests were received for copies of the charts. While the cost of their reproduction in reduced form will be considerable, studies and estimates of the cost are being made with the expectation that a practical way will be found for their reproduction in the Journal in the near future.

See also the editorial on page 399 and Dr. Hagerty's report of the House of Delegates on page 433.

THE NEW JERSEY HOSPITAL ASSOCIATION

The New Jersey Hospital Association is a very live organization now in its eleventh year. Its members represent the hospitals of New Jersey, about eighty in number, including both the general community hospitals and those of the State type, such as the tuberculosis and the mental institutions. Executives and managers of the hospitals, either lay or medical, are eligible for membership and office, and physicians are welcomed to the meetings and are often invited as speakers. The Association fully recognizes the dependence of hospitals on physicians for giving medical and surgical service; but it deals primarily with hospital activities of a non-medical nature, such as supplies, nursing, raising funds, collecting bills, and internal management.

The Association held its eleventh annual meeting on Thursday and Friday, June 14 and 15, during the week of the annual meeting of the American Medical Association, with about 200 members in attendance. The practical scope of its activities is indicated by the list of committees listed on the program. In addition to the usual committees necessary to conduct the internal affairs of the Association, there were committees on the relations of hospitals to other organizations, both official and civic.

The *Committee on Compensation Insurance* deals with cases growing out of the Hospital Lien Act. Among the other subjects considered by the committee are court subpoenas, the use and abuse of case records in law suits, and the duty of hospitals in public accidents.

The *Hospital Advisory Committee* to the Emergency Relief Administration is similar to that in The Medical Society of New Jersey, and is equally efficient.

The *Joint Insurance Committee* acts with the Casualty Underwriters Association and other insurance groups, and The Medical Society of New Jersey in the securing of amicable settlements in claims in accident and sickness cases.

The *Publication Committee* issues a four-page quarterly bulletin of the Annual Meeting. It also issues a 28-page program from which it receives a substantial income from advertisers, the privilege of exhibiting their wares at the annual meeting being a part of the contracts.

There is a *Joint Welfare Committee* to act with The Medical Society of New Jersey and a Legislative Committee.

All these committees made reports which proved the existence of a spirit of coöperation toward all other organizations engaged in delivering the services of health and comfort.

The scientific program listed about twenty formal papers.

ADDRESS OF COMMISSIONER ELLIS

President William J. Ellis, Commissioner of Institutions and Agencies of the State of New Jersey, emphasized the importance of coöperation between hospitals and physicians in the daily routine of the care of the sick, more especially since this problem has become so complicated by the extent of free service involved, and the unavoidable necessity of resorting to State and National financial assistance. These recent developments make it particularly necessary, he said, that the professional organizations of the hospitals work together with those of the physicians in attempting to guide new-born policies in the care of the sick in such a way as to prevent their encroachment on the essential and warm confidence which can exist between the physician and his patient only so long as direct contact continues without bureaucratic or other non-professional interference.

He spoke also of the increased load of non-paying patients in general hospitals, and said that the Emergency Relief Administration since its organization paid out nearly $8,000,000 for medical purposes including physicians' fees, hospitals, nursing and dental services and medical supplies, and that at the present time the monthly schedule of the E. R. A. is approximately $100,000 for physicians' fees, $20,000 for dental service, $3,000 for nursing service, $45,000 for medical supplies, and $100,000 for hospital service.

In speaking of highway accident cases, Commissioner Ellis estimated that, through the application of the Lien Law, hospitals have been able to recover close to $1,000,000 since its adoption in 1930.

He reminded his audience of the important rôle which the hospital can play in providing for the chronicly ill, lending help in the difficult struggle with mental disease, and going forward with development of mental hygiene clinics and other preventive as well as curative measures. The hospital must assist in the cancer problem and in the syphilis program.

In closing, the Commissioner said that the hospitals of New Jersey because of their geographical proximity and already well established contacts, are in better position than any other State group in the nation to lead the field in active colaboration with the medical profession and other welfare groups in mobilized provision for human needs.

ADDRESS OF DR. MacEACHERN

Dr. MacEachern of the American College of Surgeons spoke on the importance of systematic supervision of hospital personnel, which should include careful selection, adequate training, initial and periodic health examinations, promotion as deserved, and whenever possible the development of a form of pension on retirement after long continued terms of service.

SYMPOSIUM

A symposium on "Hospitals in the Changing Social Order" occupied the Friday afternoon session. Mr. Chester I. Barnard, Director of the State Emergency Relief, discussed the financial aspect as it might appear to the casual lay observer. In explanation, he pointed out that because of his three-fold financial interest,—actual payment of hospital charges, voluntary contributions, and tax assessments,—the citizen has the right to expect that hospitals shall be constantly alert to spend each dollar to the best possible advantage. In this, he included all phases of hospital construction, development, and administration.

Mr. F. Stanley Howe, Director of the Orange Memorial Hospital, replied to Mr. Barnard's challenge by defining the responsibility of society as a group for the maintenance of adequate hospitalization. Admitting that the public has a right to expect efficient hospital performance organized on a community-wide plan, he showed that in recent years many localities had failed in providing adequate support to the extent that needed hospitals had been closed, and in many others unquestionably necessary activities had been dangerously curtailed. While the cost per day of hospital care is admittedly greater than it was ten or more years ago, he cited proof that cost of hospitalization had been much reduced because improved technic in medical and surgical diagnosis and treatment had shortened the length of stay. He mentioned the great need for public distribution of information regarding the vast improvement in hospital care and results; and expressed regret that the press habitually featured unfortunate accidents, no matter how rare, but failed to report the very real and constant progress in volume and quantity of hospital work.

On the same program Dr. Helen C. Manzer, Director of Public Health Nursing of the University of New York, discussed the importance

of nursing education suited to the demands of the times.

Mr. Robert E. Neff, Administrator of the Iowa University Hospitals, spoke on the organization and purpose of the *American College of Hospital Administrators*, of which he is the President. Requirements for fellowship are adequate educational and personal qualifications, and ten years or more of actual experience as a hospital administrator. For membership, the requirements are five years of experience as administrator, and adequate educational and personal qualifications acceptable to the membership committee of the organization.

The stated purpose of the College is to elevate the standards of hospital administration, to establish a standard of competency for hospital administrators, to develop and promote standards of education for their training, to inform hospital trustees and the public concerning the complexities of hospital administration and the importance of selecting an administrator of adequate training and experience, and to confer fellowships and memberships upon those administrators who are rendering noteworthy service as chief executive of hospitals.

Dr. Bert W. Caldwell, Executive Secretary of the American Hospital Association, reported on the growing strength and importance of the Association, its accomplishments, aims, and future plans, including the publication of a monthly journal.

Dr. Thomas A. Clay of the Paterson General Hospital discussed the problem of "Dispensary Control", outlining a method for reducing the abuse of dispensary care by persons financially able to pay for private medical treatment.

Dr. W. F. Barry, of the State Board of Dentistry, described the important contribution to thorough hospital service which can be made by the dental interne.

Progress in group hospitalization was outlined by Mr. Frank Van Dyk, Director of the newly organized Associate Hospital Service of New York.

Prof. Adolph F. Marquier, of the Rutgers University College of Pharmacy, talked on the "Hospital Pharmacy", describing its organization and routine, and especially the financial advantage that can be gained by following the pharmacopoeia and the National and the New Jersey formularies.

Dr. Mary Bryan, Department of Institutional Management of Teachers' College, Columbia University, took advantage of the wide discussion of food-therapy current in the A. M. A. meetings to bring to the hospital group an interesting paper on the importance of the patient's diet in the hospital. She gave practical advice on economy in purchasing.

Miss Nina D. Gage, from the School of Nursing of the Jersey City Medical Center, described many new avenues of employement open to graduate nurses and the special course of instruction available for preparation for such work.

The Saturday afternoon session was occupied by a round-table discussion directed by Mr. Edgar C. Hayhow, Superintendent of the Paterson General Hospital. The subjects were:

1. Progress Toward University Nurse Education, by Miss Eva Caddy.
2. Coöperative Purchasing, by Miss Cora E. Gould, Purchasing Agent, Orange Memorial Hospital, Orange.
3. Care of Hospital Equipment, by Mr. Louis Roth, Superintendent, Barnert Memorial Hospital, Paterson.
4. The Organization and Functions of an Ideal Woman's Auxiliary, by Dr. Charles H. Young, Director, Mountainside Hospital, Montclair.
5. Collecting Hospital Accounts, by Mr. James R. Mays, Superintendent, Elizabeth General Hospital, Elizabeth.

Officers elected for the year 1935-36 were:

President, Fred W. Heffinger, Trenton, Superintendent, Mercer Hospital.
President-Elect, James R. Mays, Elizabeth, Superintendent, Elizabeth General Hospital.
Treasurer, Thomas J. Golden, Jersey City, Assistant to the Director, Medical Center.
Executive Secretary, Rev. John G. Martin, Newark, Superintendent, St. Barnabas Hospital.

The New Jersey Association of Medical Social Workers, the New Jersey Occupational Association, and the New Jersey Dietetic Association met with the hospital group. Dr. G. M. Knowles, from the Hackensack Hospital, addressed the Dietetic Meeting on the "Problems of the Doctor in the Management of Diets", and Dr. C. A. Losada, of Fair Oaks Sanatorium, spoke on the value of the Occupation Therapy Association.

THE FEDERAL SOCIAL SECURITY BILL

The Federal Social Security Bill, H. R. 7260, was discussed on Wednesday, June 26, at an informal meeting of representatives of the several state-wide health agencies of New Jersey, assembled in Trenton, on the invitation of The Medical Society of New Jersey. Those present were:

From The Medical Society of New Jersey:
- W. G. Herrman, M.D., Asbury Park, Second Vice-President.
- Stanley Nichols, M.D., Asbury Park, Chairman, Committee on Public Health.
- D. Leo Haggerty, M.D., Trenton, Chairman, Sub-Committee on Legislation.
- H. H. Satchwell, M.D., Irvington, Chairman, Committee on Hospitals and Medical Education.
- LeRoy A. Wilkes, M.D., Trenton, Executive Secretary.

From the State Department of Health:
- J. Lynn Mahaffey, M.D., Commissioner.
- Charles J. Merrill, Bureau of Administration.
- William H. MacDonald, Bureau of Local Health Administration.

From the Dental Association:
- John S. Owens, D.D.S., Camden, Secretary of the Conference of Allied Medical Professions.

From the Department of Institutions and Agencies:
- William J. Ellis, L.L.D., Commissioner.
- Joseph A. Alloway, Chief, Division Old Age Relief.

From the Department of Education:
- Allen G. Ireland, M.D., Trenton, Director of Health and Physical Education.

From the State Hospital Association:
- Fred W. Heffinger, President, Superintendent Mercer Hospital, Trenton.

From the Pharmaceutical Association:
- Robert P. Fischelis, Pharm.D., President State Pharmaceutical Association.

From the State Nurses' Association:
- Miss Evelyn Walker, R.N., Red Bank, Monmouth County Organization for Social Service.
- Miss Hettie Seiffert, R.N., Elizabeth, Public Health Nursing.
- Miss Margaret Ashmun, Orange, President, Public Health Nursing Association.
- Miss Grace Watson, Jersey City Medical Center, Educational Director.

Dr. Herrman presided, and Dr. Wilkes acted as Secretary.

Dr. Hermann stated that the meeting was called to study:

1. The implications of the Social Security Bill as it may affect New Jersey.
2. The enormous health problems and questions which it brings before this joint group.
3. Plans that may work for the best interest of the people of the State.

Dr. Nichols asked three questions for the different groups to answer:

1. From the standpoint of the Department of Health and the medical profession, what are New Jersey's most immediate health needs for the six groups involved that will benefit by the bill? (The six groups are: Maternal health, child health, dependent children, crippled children, the blind, and public health.)
2. What projects has your department or profession set up or contemplated to meet the needs you regard as important?
3. To what economic level should the recipients belong who are going to participate in these specific subsidies?

Dr. Wilkes stated that he had studied the bill and found it very much involved and requiring considerable thought. The bill deals largely with generalized aims; sets up definite groups who will be charged with the approval of the plans to be submitted by the different states; gives the allotments to be made with the different catagories; and states the method of collecting taxes and the estimated amounts. The final authority on all plans is the Society Security Board composed of three members.

Dr. Mahaffey reported that he and Mr. MacDonald had been in Washington last week and listened to the discussion on the bill. Enabling legislation may have to be passed in New Jersey before the State can participate in all these funds. Washington is urging all commissioners of health to be cautious about expenses that might be criticized.

Miss Walker stated she had studied the bill for some time. The nursing group wishes to have a division of Public Health Nursing in the State Department of Health.

Mr. MacDonald reported on a conference of State and sectional health officials held before the Surgeon General of the Public Health Service. It was his understanding that public health service funds were to be allocated by the Public Health Service to the various State Health Departments. A Department of Health would employ certain classes of workers who would

be paid in each field as its employees. The money would come from Washington to the State Treasurer marked for this purpose; but these workers would be State employees and would meet State requirements. The bill provides assistants to the State, County, and District Health Departments.

The funds in the Children's Bureau marked for Maternal and Child Welfare are to be expended through the State Health Departments. The Bureau proposes to be very liberal as to the terms "maternal and child welfare". It may be possible to use the fund for diphtheria toxoid and its administration. Free biologicals might also come under this fund. The money is primarily to supply nursing and other services to mothers and children through the State Health Department, and be expended in accordance with the Health Department's plans. The fund is also for the crippled and blind, with the word "crippled" being given a wide interpretation.

Dr. Mahaffey reported that the States of New York, Pennsylvania and Connecticut felt that the Western and Southern states would profit most by this bill. New Jersey in 1934 sent $97,000,000 to the Federal Government and received back $4,000,000. Alabama sent $4,000,000 and received $18,000,000. He believes we should make an effort to get an appropriation for any health measure that we feel comes up to our standard.

Miss Seiffert stated that the nurses wished the Health Department to institute a generalized nursing service which would be a great help to the nursing agencies in the State. About 55 per cent of the public health nurses in the State are under private agencies. About 500 nurses work alone in the rural districts, and many are not progressing in their work. The nurses also want scholarships in order to prepare themselves for better jobs.

Dr. Satchwell stated his interest was in the Washington plan of medical service. The medical profession is attempting to put over something to bring the patient, the hospital, and the physician into contact with one another. The Washington plan may be substituted for health measures.

He believes this Security Bill to be dangerous and the State Departments should go slowly and do nothing that cannot be stopped quickly. He believes the Washington Plan will take root in this State.

Commissioner Ellis expressed his appreciation to the Medical Society for its initiative in calling this group together to discuss the bill. He stated that we do not know enough of this bill or whether it is constitutionally sound; and we should not take hasty action. Public opinion in New Jersey is going to look over very carefully any taxation in this State within the next two years. All social security legislation is based on the philosophy that the locality will be taxed when Federal funds have been exhausted.

Commissioner Ellis favors the care of the indigent aged, with 65 as the age limit. By lowering New Jersey's age limit to 65, it would double our responsibility, but we would get back enough to take care of this increased cost. However, if this act were to be declared unconstitutional, and we did not receive these funds, the people would have to be taxed to take care of this extra load.

Commissioner Ellis advised the Board of Freeholders to back Senator Barbour's recommendation to have a commission make a survey. The group was to consist of nine members,—three assemblymen, three senators, and three citizens to be appointed by the Governor. It was recommended that the number of citizens be raised to nine.

Dr. Owen reported the dentists would coordinate their efforts with the other groups. A separate project, which they have carried on since January, 1934, will come under this Act. This project is being carried on through Dr. Ireland's School Department. He feels these medical services should work through some Executive Committee.

Mr. Heffinger announced he was most interested in this bill because, while there is no evidence that actual funds will go directly or indirectly to the general hospitals, yet welfare money spent in the state will help lessen the load on the hospitals. Most hospitals now are existing on E. R. A. money; and if this is taken away each would have a deficit.

The Conference adopted the motion of Commissioner Ellis that "this group request The Medical Society of New Jersey to call this representative group together in an informal manner periodically, to exchange views".

LEROY A. WILKES, M.D.,
Secretary.

THE LEGISLATURE

The Legislature of New Jersey closed its session and adjourned sine die on Tuesday, June nineteenth.

The Chiropodist Bill, A-150, had passed the Assembly, but died in committee in the Senate. This bill would extend the field of the chiropodists' practice from the foot up to the knee.

Senate passed a bill, S-313, to enable one individual to obtain a license to practice medicine although he had failed to secure the degree of Doctor of Medicine (Transactions p. 38). This bill died in the Assembly.

The Beauticians' Bill, A-414, placing beauty parlor operatives under the jurisdiction of the State Department, was passed by both Houses of the Legislature; but the Governor refused to sign it, on the ground that it was merely regulatory and not a health measure. The beauticians, therefore, framed another bill setting up a special board of examiners. This bill was enacted by both Houses and signed by the Governor.

The Legislature passed and the Governor signed a bill, S-333, providing court clinics for mental diagnoses in behavior cases. This bill was founded on the experiment of Judge Stanger, of Cumberland County, who appointed three consultants, a Physician, a Psychologist and a Probation Officer, to hold clinics for the mental examination of those under arrest, and advising the judge regarding their sentences or releases. There was considerable opposition to the bill on the ground that the word *psychologist* is an unauthorized term and may be applied to a college student as well as to the head of the department of psychology. But it was felt that the intention of the law was good, and that its adpotion and operation would be a step toward a wider application and clarification of medical testimony.

MEDICAL VETERANS OF THE WORLD WAR

One of the interesting events of the A. M. A. Convention Week at Atlantic City was the annual dinner of the Medical Veterans of the World War on Wednesday evening, at Kornblau's Restaurant.

The President of the Veterans, Major Albert G. Hulett, Med. Res., U. S. A., of East Orange, presided and introduced several distinguished guests and visitors both from the United States and Canada. Following a fine shore dinner, during which enjoyable music was offered by a string trio, a number of speakers addressed the assemblage, both reciting humorous and reminiscent war experiences, and also stressing the imperative necessity for the attainment of more active interest and participation by the medical profession in matters of national defense and security as regards the medical services, and the wisdom of a far more adequate organic representation before Congress.

The Guest of Honor was Major General Charles R. Reynolds, U. S. A., recently appointed Surgeon General of the Army. Among the speakers were Major General Harry L. Gilchrist, Chemical Welfare Service, U. S. A., retired, and now Editor of the Military Surgeon; Col. John C. McCullough, National Guard, N. J.; Col. L. C. Auston, Canadian Army Medical Corps, Professor of Surgery in Queen's University in Canada; Lt. Col. Frank Overton, Editor of The Journal of The Medical Society of New Jersey; Col. Harold Corbusier, Medical Reserve, of Plainfield, and Capt. William Seaman Bainbridge, M. C., U. S. N. R., President of the Association of Military Surgeons of the U. S.

The Mayor of Atlantic City was represented at the dinner by Major Casey, Director of Public Work, who extended the official welcome of the city and presented Major Hulett with the gold key of Atlantic City in token of goodwill.

Those attending the dinner joined in singing many of the songs of war-service days, and the many memories of the evening's pleasures will linger until the next annual dinner arrives. Those in attendance expressed their appreciation to Major Hulett, as President, and to Lieutenant Commander Allman, of Atlantic City, as Arragement Chairman, for the profitable evening enjoyed. The meeting afforded a real opportunity for both pleasure and profit for those who believe in "Preparedness".

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING MAY, 1935

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
David F. Haagen	51	May 11, 1935	St. Peter's Hospital, New Brunswick	York, Pa.	Lobular pneumonia
Fred S. Caverly	52	May 15, 1935	127 Madison St., Clifton	Same	Intracranial hemorrhage and hemiplegia.
Nelson Y. Hull	68	May 5, 1935	521 E. Second St., Plainfield	Same	Endocarditis.
John J. Lettieri	42	May 7, 1935	515 Palisade Ave., Union City	Same	Pulmonary tuberculosis.
George B. Philhower	73	May 23, 1935	St. Barnabas' Hosp., Newark	281 Grant Ave., Nutley	Terminal pneumonia. Cerebral accident. Degenerating tumor of left femur.
Alexander Marcus	33	May 27, 1935	Beth Israel Hosp., Newark	55 Oxford St., Newark	Lobar pneumonia. Empyemia. Endocarditis.
James W. Fox	62	May 2, 1935	556 Hillsdale Ave., Hillsdale	Same	Diabetes mellitus. Cardio vascular insufficiency.
Thomas H. Wright	53	May 26, 1935	Cedar Grove	768 High St., Newark	Gen. arterio sclerosis. Cardio renal disease. Lues. Psychosis with cerebral arterio sclerosis.
Adam M. Miller	56	May 28, 1935	90 Briarcliff Rd., Mountain Lakes	Same	Cerebral hemorrhage. Gen. arterio sclerosis.
Robert C. Howard	51	May 4, 1935	Long Pond Rd., West Milford	Same	Angina pectoris.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS

DIPHTHERIA TOXOID

County	To Apr. 30	Average per Month	Month of May	Total to May 31
Atlantic	187	18.7	45	232
Bergen	1982	198.2	539	2521
Burlington	72	7.2	31	103
Camden	281	28.1	21	302
Cape May	85	8.5	19	104
Cumberland	65	6.5	118	183
Essex	2073	207.3	342	2415
Gloucester	607	60.7	399	1006
Hudson	249	24.9	14	263
Hunterdon	85	8.5	4	89
Mercer	35	3.5	18	53
Middlesex	839	83.9	66	905
Monmouth	512	51.2	196	708
Morris	638	63.8	177	815
Ocean	43	4.3	14	57
Passaic	2313	231.3	743	3056
Salem	77	7.7	117	194
Somerset	800	80.0	13	813
Sussex	403	40.3	177	580
Union	473	47.3	530	1003
Warren	56	5.6	12	68
Totals	11875	1187.5	3595	15470

County	To May 31	Average per Month	Month of June	Total to June 30
Atlantic	232	21.1	61	293
Bergen	2521	229.1	711	3232
Burlington	103	9.3	44	147
Camden	302	27.4	64	366
Cape May	104	9.4	10	114
Cumberland	183	16.6	191	374
Essex	2415	219.5	613	3028
Gloucester	1006	91.4	119	1125
Hudson	263	23.9	3	266
Hunterdon	89	8.1	64	153
Mercer	53	4.8	13	66
Middlesex	905	82.2	151	1056
Monmouth	708	64.4	51	759
Morris	815	74.1	66	881
Ocean	57	5.1	6	63
Passaic	3056	277.8	621	3677
Salem	194	17.6	28	222
Somerset	813	73.9	12	825
Sussex	580	52.7	115	695
Union	1003	91.1	235	1238
Warren	68	6.1	28	96
Totals	15,470	1406.3	3206	18,676

SMALLPOX VACCINE

County	To Apr. 30	Average per Month	Month of May	Total to May 31
Atlantic	129	12.9	6	135
Bergen	602	60.2	102	704
Burlington	87	8.7	38	125
Camden	223	22.3	15	238
Cape May	445	44.5	14	459
Cumberland	32	3.2	34	66
Essex	1172	117.2	141	1313
Gloucester	278	27.8	24	302
Hudson	10	1.0	13	23
Hunterdon	68	6.8	27	95
Mercer	24	2.4	6	30
Middlesex	624	62.4	51	675
Monmouth	36	3.6	31	67
Morris	420	42.0	105	525
Ocean	42	4.2	21	63
Passaic	1113	111.3	271	1384
Salem	92	9.2	109	201
Somerset	244	24.4	5	249
Sussex	30	3.0	87	117
Union	244	24.4	239	483
Warren	95	9.5	7	102
Totals	6010	601.0	1346	7356

County	To May 31	Average per Month	Month of June	Total to June 30
Atlantic	135	12.2	299	434
Bergen	704	64.0	246	950
Burlington	125	11.3	31	156
Camden	238	21.6	22	260
Cape May	459	41.7	24	483
Cumberland	66	6.0	141	207
Essex	1313	119.3	556	1869
Gloucester	302	27.4	34	336
Hudson	23	2.1	1	24
Hunterdon	95	8.6	80	175
Mercer	30	2.7	224	254
Middlesex	675	61.3	56	731
Monmouth	67	6.1	28	95
Morris	525	47.7	142	667
Ocean	63	5.7	11	74
Passaic	1384	125.8	235	1619
Salem	201	18.2	25	226
Somerset	249	22.6	23	272
Sussex	117	10.6	24	141
Union	483	43.9	216	699
Warren	102	9.2	37	139
Totals	7356	668.7	2455	9811

COUNTY SOCIETY REPORTS

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The May meeting of the *Bergen County Medical Society* was in the form of a Spring Festival at Bergen Pines beginning at 2 o'clock and lasting until 7 p. m. on Wednesday, May 22nd. After an afternoon of sports including baseball, archery, horse shoes, golf, and tennis, the doctors assembled for an excellent scientific program which had been prepared by Dr. Joseph R. Morrow and his Staff at Bergen Pines with the help of our Program Committee. The meeting was called to order by Dr. J. H. Irwin.

NEW MEMBERS

The following were elected to membership:

From Junior to Regular—

Dr. H. Oren, Park Ridge

Dr. J. M. Coppoletta, Cliffside Park

Junior—

Dr. Rubin Grossman, Garfield

The following applications for membership were read:

Regular—

Dr. E. W. Probst, Rutherford

Dr. Ernesto Iannuzzi, Grantwood

Junior—

Dr. Frank Blalock, Bergen Pines

Dr. E. Fishbine, Bergen Pines

Dr. Frank P. Iorio, Leonia

Dr. William H. Knight, Oradell

For Reinstatement to Regular Membership—

Dr. J. A. Villegas, Grantwood

COMMUNICATIONS

The following communications were mentioned by the Secretary:

A note of appreciation from Mrs. James Fox thanking the Bergen County Medical Society for expressions of sympathy at the time of the death of her husband, Dr. James Fox.

Legislative Bulletin No. 4, in regard to the Osteopathic Bill, the Chiropodist Bill, the Beauticians' Bill and S-313.

A letter from McConnell & Fergusson, Advertising Agency of Vancouver, Canada.

A letter from Mr. Blanksteen of the Health & Accident Insurance Company to ascertain whether two of our members were in good standing.

Certificate of Incorporation of the Bergen County Medical Society.

CONSTITUTION

After a motion by Dr. C. Littwin, the changes in the Constitution and By-Laws as proposed by Dr. D. Hull, Chairman of that committee, which were announced at the two preceding meetings, were adopted as follows:

Chapter III Section 2—Add in the third line after the word New Jersey "and in neighboring States". At the end of this Section add the words "Associate membership dues shall be $5.00 per year."

Chapter VIII—Strike out the word "seven".

Then in Article V in the Constitution under Officers and Elections, line three, substitute "Spring" for "January".

SCIENTIFIC PROGRAM

Dr. David Goldberg introduced Dr. J. R. Morrow, Superintendent of Bergen Pines, who announced that it was desirable for the family physicians to attend the Staff Conferences on each Monday at 11 a. m., particularly when their private patients were up for discussion. Doctors were also invited to attend the operations on Fridays.

Dr. George Finke, Director of Surgery of Bergen Pines, reported on eighteen cases on whom thoracoplasty operations, usually in two stages, had been performed since November, 1933. There were two deaths among the eighteen.

Dr. William Spickers, of Paterson, presented three of the cases and showed lantern slides to illustrate the technic of the operation.

Dr. R. M. Anderson, of Hackensack, described the indications for thoracoplasty and presented one case.

Dr. O. Bernardini discused collapse therapy.

Dr. George Ornstein, who is in charge of the Tuberculosis Division of the Metropolitan Hospital of New York City and also of the Sanitarium at Sea View, congratulated Bergen Pines on the conservative work done by its surgeons as indicated by the good results with the 12 per cent mortality. He stated that the usual mortality during the first year is around 33 per cent. Surgery in pulmonary tuberculosis is important as indicated by the fact that there are 150 surgical cases at Sea View today, whereas twelve years ago there were only one or two. It is important to determine the type of pulmonary tuberculosis before operation. Operation should be performed only on the exudative, caseous, pneumonic type in which a cavity has developed and in which the prognosis is bad unless the cavity be destroyed.

In the productive type of tuberculosis, operation is not indicated; the disease will run its course as a rule.

The meeting was adjourned, and a buffet supper was served by the Bergen Pines Culinary Department.

The regular meeting of the *Bergen County Medical Society* was held in the Holy Name Hospital on June 25, at 9 p. m.

NEW MEMBERS

The following were elected to membership:

Regular—

Dr. E. W. Probst, Rutherford

From Junior to Regular—

Dr. E. E. Wolfe, West Englewood

Dr. I. M. Levitas, Westwood
Dr. Andrew Ferrari, East Rutherford
Dr. Christian P. Segard, Leonia

Junior—

Dr. William H. Knight, Oradell
Dr. Frank P. Iorio, Leonia
Dr. E. Fishbeln, Bergen Pines
Dr. Frank Blalock, Bergen Pines

COMMUNICATIONS

A letter from Dr. H. W. Nafey, Secretary of the Board of Trustees of The Medical Society of New Jersey, in which he urged us to take steps in any and all abuses violating the spirit and letter of the agreement with the Emergencf Relief Administration.

A letter from Mr. John J. Toohey, Commissioner of Labor of the New Jersey State Department of Labor, in which he urged the doctors to examine compensation cases in their proper places and not on the premises of the Department of Labor.

AUTOMOBILE INSURANCE

The Secretary read a telegram from Mr. Harry Fleuchans, of the Way Agency, Inc., in regard to the assistance which his company offers the settlement of claims.

FEE SCHEDULE

Dr. J. H. Irwin urged that we approve of the fee schedule as drawn up in 1934 as a guide for the physicians' fees under the 1935 law. Dr. S. T. Snedecor pointed out that such action would result in an establishment of a definite fee schedule resulting in many difficulties. Action was postponed to the September meeting.

NATIONAL SOCIAL SECURITY BILL

Dr. Snedecor called attention to the passage by Congress on June 2nd of the *Social Security Bill* with its public health projects for the establishment of another child health bureau and other health measures. He mentioned the Central Investigating or Credit Bureau under the so-called Washington Plan which is being tried in Newark. He moved that the Clinic Committee be empowered to investigate the plan; and if necessary, to go to Washington to confer with Dr. A. C. Christie and to report back at the September meeting. Motion was seconded by Dr. Paul Angelillis and approved.

The Treasurer reported an estimated deficit of $430.00 for the balance of the year.

SCIENTIFIC

The meeting was then turned over to Dr. Vincent Farmer, who had arranged the Scientific Program. The program was unique in that the Hackensack, Holy Name and Englewood Hospitals each presented and discussed one gastro-enterological case. Each of the cases was discussed by Dr. Burrill B. Crohn, Gastro-enterologist at the Mt. Sinai Hospital.

Meeting was adjourned for refreshments.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

EXECUTIVE COMMITTEE REPORT

The regular meeting of the Executive Committee of the *Monmouth County Medical Society* was held on Monday evening, May 13, at the Fitkin Memorial Hospital, Neptune, with the following men present: Drs. Fairbanks, Gosling, Hunt, Holters, Kazmann, Parry, Pregnall, Herrman and Fisher.

BLANKS FOR LIEN LAW

Dr. Holters moved that copies of the Physicians' Lien Law be sent as special bulletins to all members of the County Society, together with all forms necessary to place lien and release same. Motion seconded by Dr. Herrman, and passed.

Dr. Herrman moved that Attorney Theodore Parsons be requested to lift the fee schedule from the County Clerk's office, if this is possible. Motion seconded by Dr. Fairbanks and passed.

E. R. A. EXPENSE

Moved and seconded that E. R. A. Committee contact all doctors doing E. R. A. work, to ascertain if the doctors would be willing to contribute 10 per cent of their monthly income, not to exceed $10.00 per month, to curtail any expense incidental to medical E. R. A. in Monmouth County, the surplus to be converted to the general treasury of the Monmouth County Medical Society. Motion passed.

REGULAR MAY MEETING

The May meeting of the *Monmouth County Medical Society* was held at the New Jersey State Hospital, Marlboro, New Jersey, on Wednesday evening, May 22, at 8:30 o'clock, Dr. W. H. Fairbanks presiding. Approximately sixty members and guests were present.

Mr. W. Blanksteen of the National Casualty Company was allowed ten minutes to explain the State Society's group accident and sickness policy.

The report of the Exccutive Committee was accepted with a few minor changes, after the minutes of the previous meeting were read and approved.

Applications for membership were received by the following men:

Dr. J. G. Feman, Keansburg, N. J.
Dr. Gregory E. Sacco, Red Bank, N. J.
Dr. Ralph G. Woodruff, Englishtown, N. J.

The meeting was then turned over to Dr. J. Berkeley Gordon, Medical Director of the New Jersey State Hospital, Marlboro, New Jersey, for the presentation of the following paper:

1. Prophylaxis in Mental Disease—Dr. G. L. Jones
2. Physical Factors in Mental Disease—Dr. J. A. Toren
3. Psychogenic Concept of Mental Disease—Dr. E. F. Baker

These papers will be submitted to the State Journal for publication.

HOSPITAL CONFERENCES

The following program was presented at the regular monthly clinical conference of the Monmouth Memorial Hospital on Wednesday evening, May 15:

1. Statistical Study of Gall-Bladder Disease in Monmouth Memorial Hospital in year 1934—Dr. George Hunt
2. Statistical Study of Hysterectomies in Monmouth Memorial Hospital in year 1934—Dr. Harold Kazmann
3. Cyst of Third Ventricle of Brain—Dr. R. Pietri
4. Rupture of Uterus Due to Chronic Infection of Old Cesarean Section Wound—Dr. Robert MacKenzie
5. Di-cephalic Monster—Dr. William Shanik

The following program was presented at the clinical conference of the Fitkin Memorial Hospital May 21, 1935:

1. Bilateral Pyonephrosis in a Child Aged 4—Dr. Charles Prout
2. Acute Pancreatitis with Recovery—Dr. O. K. Parry
3. Cardiospasm (2 cases)—Dr. Louis Albright
4. Pyloric Stenosis (case)—Dr. Carlos Pons
5. Carcinoma of Kidney (case)—Dr. Samuel Edelson.

MORRIS COUNTY

Marcus A. Curry, Reporter

A regular meeting of the *Morris County Medical Society* was held the evening of Thursday, June 20, at The New Jersey State Hospital at Greystone Park. President McMahon called the meeting to order with about forty members and guests present.

SCIENTIFIC

Dr. Charles W. Stiles, of Washington, D. C., was introduced as the speaker of the evening. His subject was "Some Medical Zoölogical Aspects of the Race Problems in the South", which he covered in a novel and interesting manner, drawing from his experience as Chief of the Department of Etiology of the Federal Public Health Service. He considered it one of the most interesting things in his life to get away in the summer and exchange views with his colleagues in other lines of thought. As an added qualification to speak on his subject, he mentioned that most of his life has been spent south of the Potomac.

In speaking of the South, it is best to think of it not as one land, but as three regions, with three types of people,—the *clayland* region whose people correspond to the Northerners, the *sandland* region, and the *mountain* area. The inhabitants are of three different anatomical types with a difference of characteristics.

The speaker also delved into the problem of the negros, their economic handicap, the tropical diseases which they have brought. He compared their immunity to these with the severity of tuberculosis with which they have been infected by the whites in exchange for malaria and other tropical diseases. Tuberculosis is a disease of the crowd, and has no incidence in the wide open spaces of Africa from which the Negro race was brought to North America. This explains the fundamental biological law, that the more homogeneous the race, the more harmony in it; and the more heterogeneous, the more disharmony.

Dr. Stiles' discourse was interesting from many angles and was interspersed with a recitation of humorous incidents. Questions were asked, to which Dr. Stiles made ready and adequate response.

NOMINATION OF OFFICERS

Dr. Frost, Chairman of the Nominating Committee, made the following recommendation of officers for next year, to be voted upon at the September meeting:

President—William F. Costello, Dover
Vice-President—Byron G. Sherman, Morristown
Secretary—Attilio Galasso, Morristown
Treasurer—George J. Young, Morristown
Reporter—Marcus A. Curry, Greystone Park
Historian—L. L. Mial, Morristown.

Delegates to the State Society for two years:
Stanley Teskey
Edward T. Carberry
Alternates:
Dr. Teller
Dr. Spencer

STATE MEETING

Dr. Frost made an interesting report on various matters that occurred at the State Society meeting of fundamental interest to the medical profession.

WOMAN'S AUXILIARY

Dr. Elvira Dean Abell made a preliminary report on the organization of a Woman's Auxiliary in Morris County.

LIEN LAW

Dr. Frost reported on the Physicians' Lien Law and action was duly taken authorizing the printing of the blanks by the Society to be furnished to the members at cost.

CONSTITUTION

The following changes in the Constitution of the Society were unanimously approved:

"That every meeting shall be a regular meeting" and that "The annual meeting of the Society shall be changed from September to June, in order to correspond with the fiscal year of the New Jersey State Medical Society."

NEW MEMBERS

Four new members were unanimously admitted; these being Dr. Ruth Earp, of Bernardsville, on transfer; Dr. John M. Atkinson, of Hanover; Dr. Edward J. Jenkins, of Whippany, and Dr. Ivan B. Smith, of Dover.

After adjournment about midnight a collation was enjoyed in the hospital cafeteria.

THE WOMAN'S AUXILIARY

THE WOMAN'S AUXILIARY

1. SOCIAL ACTIVITIES AT THE A.M.A. CONVENTION

The thirteenth Annual Meeting of the Woman's Auxiliary to The American Medical Association was held at Atlantic City, with headquarters at Hotel Traymore, June 11-15, 1935. Following a National Board supper at the Claridge, and a buffet luncheon in the Submarine Grill of the Traymore, the social festivities actually opened with a get-together dinner in the Trellis Room of the Ritz-Carlton, on Monday night, the 11th, in honor of the visiting Canadian ladies. The ladies of Camden County were hostesses immediately afterward at a musicale and reception, honoring the wives of the Canadian Medical Society. Mrs. Edward C. Pechin was Chairman for Camden County and Mrs. Harry Varsil Hubbard for Union County.

On Tuesday morning a real southern breakfast was served in the Submarine Grill in honor of Mrs. Robert W. Tomlinson, and Mrs. Rogers N. Herbert, the retiring, and the incoming national Presidents. The entire day made the visitors sea-conscious, for the Submarine Grill breakfast was followed by the famous sea food luncheon at Hackney's, and afterwards the guests chose between boat sailing and the comfort of a more quiet chair ride on the boardwalk. Tea and a musical treat followed at the Traymore.

Wednesday brought a lovely luncheon at the Traymore, with Mrs. Robert W. Tomlinson presiding, and with Mrs. W. Burrill Odenatt, Chairman. Dr. Allan Roy Dafoe addressed the ladies, telling many little details in the lives of the beloved quintuplets, and answered many questions most graciously. In the evening entertainment was furnished on the Steel Pier, followed by an informal dance.

Thursday was a busy day. Luncheon at the Ritz-Carlton was followed by a most unusual style show and bridge party, under the able chairmanships of Mrs. Laurrie D. Sargeant, Mrs. G. E. McDonnell, Mrs. Carl A. Surran. Participating in this entertainment were the Burlington and Atlantic County Auxiliaries. In the evening the "Bring-Your-Husband" dinner was held in the main dining room of the Traymore, with Mrs. Frank P. Nicholson of Hudson County and Mrs. Don Epler of Essex County as chairmen. Following was the President's Reception and Ball at the Ambassador.

Friday ushered in another glorious, sunny day for the Kickers' Golf Tournament, with luncheon at Atlantic City Country Club. Those who wished took a de luxe tour through South Jersey. With the exception of Monday, the weather was ideal, and all felt that the efforts of the ladies of Pennsylvania, Delaware, and New Jersey were well repair, for each affair showed much though and preparation. Cordiality and hospitality drew the visitors from North, South, East, and West, and from all parts of Canada together, so that they are looking forward to next year, and hope for as happy a time.

Respectfully submitted,

(Mrs. Frank P.) Edna L. Nicholson,
Reporter.

2. OFFICIAL EVENTS

Monday, June 10

9 a. m.—Meeting of General Convention.
All Chairmen of the various committees reporting on coming events.

10 a. m.—Meeting of the National Board.
Proposed recommendations.

1 p. m.—Buffet Luncheon. Submarine Grill, Traymore.
After luncheon, continuation of Board meeting.
Revision of Constitution.

7 p. m.—Get-Together Dinner. Ritz-Carlton.
Mrs. Fredreick Kinch, President of the New Jersey Auxuliary presiding.
Speaker—Wilner Keusen, M.D., Philadelphia.
Topic—The Doctor's Wife.
Address of Welcome—Mrs. A. J. Casselman, Past President of the New Jersey Auxiliary.
Remarks—Mrs. R. W. Tomlinson, President of the National Auxiliary.
After dinner, a reception and musicale, honoring the wives of the Canadian Medical Society, in the Palm Court Room.

Artists participating on this program:
Wilbur Evans, distinguished American baritone.
Morris Braun, violinist.
Joseph Uctere, cellist.
Clarence Fuhrman, pianist.
Arrangements by Camden and Union County Auxiliaries.
This was truly a real treat.

TUESDAY, JUNE 11

8 a. m.—Southern Breakfast. Submarine Grill. In honor of Mrs. R. W. Tomlinson and Mrs. R. N. Herbert.
Arranged by the Southern Auxiliaries.

9. a. m.—General Meeting. Mrs. R. W. Tomlinson presiding.
Invocation—Dr. Henry Merle Mellen.
Address of Welcome—Mrs. James Hunter, of Westville, N. J. Very gracious and just like Mrs. Hunter.
Daily Announcements—Mrs. S. L. Salasin, Atlantic City, N. J.
Report of Registration Committee—Mrs. H. Roy Van Ness, Newark, N. J.
Roll Call of State Auxiliaries—Mrs. Elmer Whitney, Detroit.
Memorial. In memory of Mrs. Preston Hunt, Past President of the Texas Auxiliary.
Minutes of twelfth annual meeting.
President's report and announcements.
Committee chairmen reports.

1 p. m.—Hackney's famous sea food luncheon.
Entertainment and music, followed by a choice of a chair ride or a sail boat ride.

4 p. m.—Musicale and tea. Library Room, Traymore.
Invitation affair—arranged by Philadelphia Auxiliary.

8 p. m.—Open meeting of the A. M. A. in the Auditorium, Convention Hall, over 8000 persons being present, and thousands more unable to find room.

WEDNESDAY, JUNE 12

9 a. m.—General meeting. Library Room. Mrs. R. W. Tomlinson presiding.
Minutes of previous meeting read.
Reports of State Presidents. Some very fine work is being accomplished. False advertising and false radio broadcasting are being exposed through the efforts of the State Auxiliaries.
Report on nominations.
Introduction of new officers.
Presentation of the gavel and President's Pin to Mrs. R. N. Herbert, the new National President.
Also presentation of pin to the retiring President, Mrs. R. W. Tomlinson, by Mrs. John O. McReynolds, of Dallas, Texas, with a very beautiful speech.

12:30 p. m.—Reception and Auxiliary luncheon at Traymore. Arranged by the Philadelphia, Bergen, Mercer and Atlantic County Auxiliaries.
Speaker—Leonard G. Rowntree, M.D.
Allan Roy Dafoe, M.D.—on the "Dionne babies".
Greetings—Walter J. Bierring, M.D., President, A. M. A.
Many pictures were taken on the Boardwalk after the luncheon.

7 p. m.—Evening entertainment. Steel Pier. Informal Dance. Arranged by the Atlantic County Auxiliary.

THURSDAY, JUNE 14

9 a. m.—Group discussions.
Post Convention Board Meeting. Mrs. R. N. Herbert presiding.

12:30 p. m.—Luncheon. Ritz-Carlton Hotel.
Style Show and Bridge Party. Arranged by Burlington and Atlantic County Auxiliaries, also the State Auxiliary of Pennsylvania.

7 p. m.—Bring-Your-Husband Dinner. Traymore. William J. Carrington, M. D., Toastmaster.
Arrangements made by Hudson and Essex Counties.
Mrs. Frank P. Nicholson, Chairman for Hudson County.
Mrs. Don A. Epler, Chairman for Essex County.

9 p. m.—President's Reception and Ball. Ambassador Hotel.

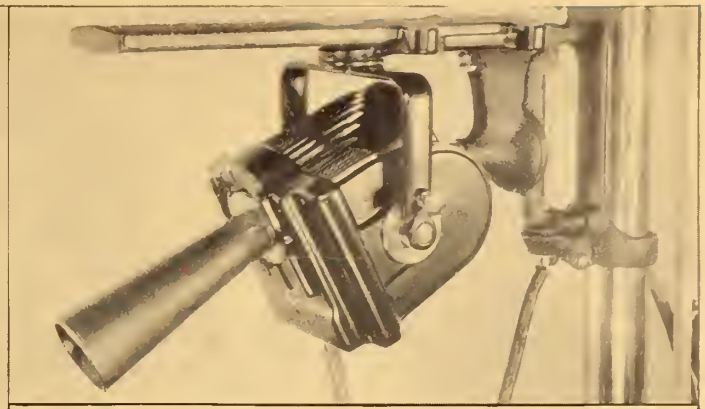
FRIDAY, JUNE 14

Golf. Sightseeing Trips.
Luncheon at the Atlantic City Country Club.
A good time was had by all.

Mrs. (Don A.) Betty Epler,
Essex County.

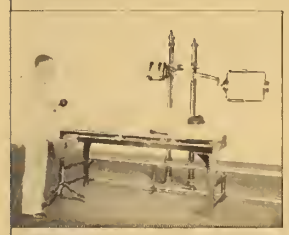






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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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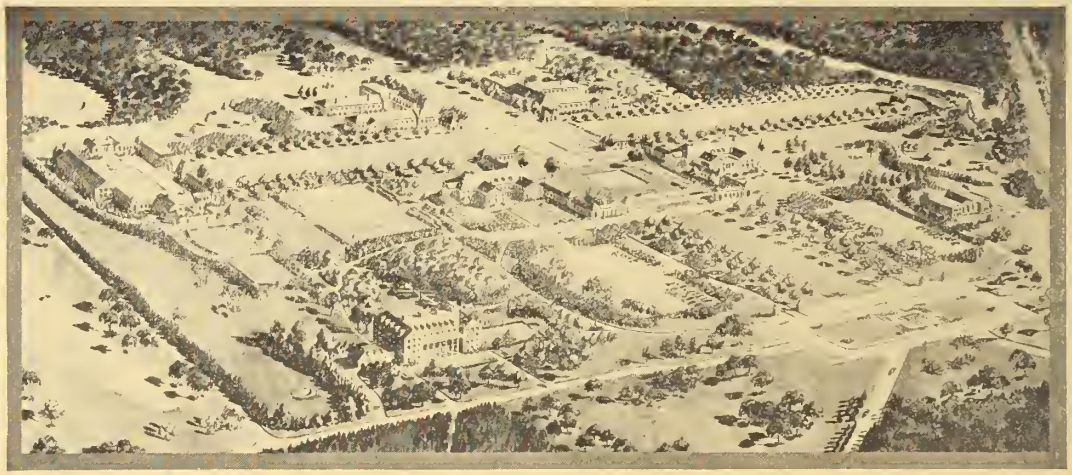
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Editor of
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Frank Overton, M.D., Dr. P.H.

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Executive Secretary—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

Vol. XXXII, No. 8 August, 1935 Subscription, $3.00 per Year
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EDITORIALS

Incorporation of The Medical Society of New Jersey

A request has come for a copy of the certificate of incorporation of The Medical Society of New Jersey, in order to establish the legality of an agreement between the Society and a lay health organization.

The Society was legally incorporated by an act of the Legislature of New Jersey passed and approved by the Governor on March 14, 1864. This act specifically took the place of a previous act of incorporation which had been passed on January 28, 1830; and this act had superseded previous acts of incorporation passed on February 10, 1818; March 7, 1806, and June 2, 1790. Moreover, the existence of The Medical Society of New Jersey had been recognized by acts of the Legislature in 1783 and 1786. The present Society is the legal continuation of the original Society which was founded on July 23, 1766.

These facts are stated in the official copy of the Constitution and By-Laws which was printed in The Journal of The Medical Society of New Jersey of October, 1934, pages 586-598, reprints of which were issued for the use of the officers and committeemen of the Society.

The significance of the incorporation of The Medical Society of New Jersey is that it gives the Society a legal standing, making it a corporate body like a bank or business corporation, whose members can not be held individually liable for the official acts of its officers and managers.

The act of incorporation also enables the Society to enforce agreements which it may make with other corporate bodies and individuals.

The act of incorporation has frequently been invoked during the past year. The Society was recognized in the Physicians' Lien Law and in agreements with the State Department of Health, in regard to the distribution of biologicals for immunizations done in the Public Health Hour. It was also recognized by the State Council on Federal Emergency Relief in signed agreements with the State Society and its component County Societies.

The basic fact of the incorporation of The Medical Society of New Jersey is so well known that it was somewhat of a surprise that proof of it should be requested.

The Report of the Bureau of Medical Economics of the A. M. A.

The report of the Bureau of Medical Economics of the American Medical Association, which is summarized on page 500 of this Journal, is of special value to every member of The Medical Society of New Jersey. The full report fills eleven pages of the June issue of the Bulletin of the A. M. A. It has a permanent usefulness as a guide to every medical society and every group of laymen who are planning to make a concrete plan for an extension of the distribution of medical service to those who are not receiving its full benefits.

A common fault in promotors of a new plan of medical service is that they cover only a few of the points which are essential. No report will have a practical value unless it considers all the points enumerated in the report of the Bureau of Medical Economics.

Dr. Leland's report is an essential text book for the use of every member of The Medical Society of New Jersey. Its careful perusal will be a deterrent to those who would enter hastily upon a survey; and an encouragement for those who earnestly desire to apply the principles of medical economics to the distribution of medical services.

The report will doubtless be in great demand in future months and years, as the physicians continue to expand their plans for a more comprehensive medical service.

Preserve your copy of the June A. M. A. Bulletin.

The Society Year

The publication of the Transactions of the Annual Meeting as a supplement to the July Journal is a natural dividing line in the year's activity of The Medical Society of New Jersey. The work of the Society has no beginning or end. It goes on continually, but like a historical play its leading actors change with each recurring year.

An officer is elected for a year and then, following a wise custom of the Society, he is advanced to a higher position; and at the end of his term as President, if he reaches that honorable goal, he is usually assigned to an important committee where his experience and knowledge continue to be available.

The activities of the Society are divided among its committees whose chairmen are the directors, each in his own sphere of influence. Each chairman with his colleagues is responsible for the development of the activities to which he is assigned. In the highest sense the chairmen are executives who design as well as carry out their projects.

The choice of the chairmen and personnel of the committees is a work of grave responsibility which devolves primarily on the President. The qualifications of the several committeemen are as varied as the work which they are expected to lay out and accomplish; and individual temperaments and knowledge of the members must always be considered in order to fit the proper man into his own peculiar niche.

The County Society is the training school for candidates for positions among personnel of the State officers. Every member of the State Society has the opportunity to progress in rank and influence. He naturally begins his service as a member of a committee of his county society; and is advanced in rank according to the high quality and broad extent of his work.

The President has a wide choice from among the 900 members of county societies who are listed as officers and committeemen, and from whom he will choose the 179 members of the personnel of his staff. (See editorial on page 59 of The Journal of February 1935.) To be chosen a member of a State Committee is an honor based on expectations of wider accomplishments in the future, as well as one's past record.

Unusual attention has been taken in the

choice of the personnel of the committees for the coming season of activities. There will be a continuity of plans and methods of the several departments of the work of the State Society. The impetus of the ever-broadening lines of activities of the past few years will carry the Society to greater accomplishments during the coming year.

Widening Contacts

The object of the Medical Profession is the delivery of all forms of medical service to the people. The physician of the past has always been ready to deliver his services to those who seek them; but the growth of civic consciousness has created a demand that the physician shall extend his plans to include not only those who request his service, but those who need them and yet do not make provision to secure them.

The ethics of the medical profession restrains the doctor from soliciting private patients; but welfare organizations have opened a new field for the solicitation of patrons. First came the activities of Health Departments in educating the people to seek the preventive benefits of medicine. Next there arose welfare organizations which gave popular health instruction to people of all classes, and prepared them to make provision for the delivery of the medical services.

It has been embarrassing for an individual physician to solicit anyone to accept his services; but The Medical Society of New Jersey has solved the difficulty by making the official Medical Societies of the several counties responsible for the solicitation of patients. The State Society project of the Public Health Hour has placed the stamp of approval on the principle that every physician should offer his services in preventive medicine to the members of those families who call him their *family doctor*. This has been a natural step in the evolution of the ethics of the practice of medicine.

The new attitude of the Medical Profession places an obligation on every physician to be an active supporter of his County Society.

It also places an obligation on the County Society to provide the machinery for delivery of the new forms of service by the family doctor. What the public hospital has done for the *individual* patient who is sick, the County Society should do for the *group* of those who are in need of *preventive* services.

Welfare organizations have assumed the rôle of the parent in dealing with the people generally. Parent-Teachers Associations, Anti-Tuberculosis Societies, Public Health Nursing groups, Health Departments, and many other organizations for the promotion of public health are actively soliciting all the people to seek the services of physicians.

The next great step in the distribution of medical services is that the Medical Societies shall establish the same contacts with the welfare organizations that the ideal family doctor makes with the heads of families who call him their family physician.

It is the policy of The Medical Society of New Jersey to establish an intimate contact with every welfare organization in the State. The State Society stands ready to send a representative to any meeting of a welfare organization; and further to advise the leaders of the organization in regard to carrying on its work. The promotion of this work will be a prominent feature of the activities of the Medical Societies during the coming year. Every doctor is honored by the opportunity to participate in this progressive work. The State Society is now "Health Conscious", and will inspire the leaders of the County Societies to adopt a similar attitude in their home localities.

The Strength of Unity

The inception of every great movement is marked with disputes and strifes between the exponents of the old order and the promotors of the new.

Every reform begins with the recognition of a real human need by a few prophets of righteousness; and then comes the formation of party groups for and against the new order of society. Misunderstanding and quarrels inevitably follow, characterized by bloody wars in the past, and by governmental upheavals in the present time.

Every reform imposes the need of extensive adaptations in the lives of great groups of people. It is a serious condition that confronts groups of workmen in an extensive industrial establishment when they find themselves deprived of their means of livelihood by a radical change in methods of manufacture. An equally serious condition confronts the medical profession when a change in the time-honored system of the practice of medicine is seriously threatened.

A fundamental fact to be considered in any great social change is that an individual cannot transmit his experience directly to his successor, but every young doctor has to pass through the same mental processes, and experience the same emotions that his predecessors endured. Knowledge may be imparted; but wisdom comes only from experience.

The average physician of today secured his knowledge twenty-five years ago, and developed a means of livelihood based on the system that existed when he was a student. The knowledge which the average person has of health is that of the doctors of a generation ago. To make a radical change in the habits of thought of either the medical profession or the people requires years of time, and a great amount of education.

We are now in the midst of an adaptation of old methods to a new philosophy of living; and progress is marked with disputes and disagreements, for that is the way of human nature. But physicians are making their adaptations with a speed that is commensurate with their high ideals, and superior knowledge and experience. They are now united in a system of medical societies whose leaders, like the generals in a battle, have a comprehensive knowledge of social conditions, and the means of establishing satisfactory relations with those groups—possibly rivals—who also seek to dominate health matters.

The meeting of the American Medical Association in June has clarified the medical situation to a degree that seemed almost visionary a few years ago.

In unity the medical profession is demonstrating its invincible strength.

Humor in Physicians

An appreciation of humor is a characteristic of the successful practitioner of medicine. To the sick person, the whole world is dark and portentious. A physical examination is an ordeal which the physician turns into a game and an exhibition of necromancy. The patient takes unpleasant medicine and likes it, and the ministrations of the doctor and nurse after an operation bring relief which is as pleasant as it is wonderful.

Humor is an understanding of human nature. The cheerful doctor is the apotheosis of comfort and joy as he turns the patient's fear into confidence, and brings a vision of renewed light and happiness to his darkened mind.

Sickness is an incongruity which offers abundant opportunities for the revelation of its inconsistencies which appear droll to even the suffering patient. The cheer which a skillful physician brings to the sick person and his anxious family is an exhibition of humor at its best,—and is as necessary as scientific knowledge and skill.

Humor is essential for the patient's acceptance of the ministrations of the doctor and the nurse. It is sympathy diverted from its darkness to the bright side of life. Blessed is the doctor who expresses his sympathy in his humor.

The Emergency Relief Administration

Physicians in New Jersey will be gratified that the essential features of the State's plan was put into operation by the State of Ohio on July first, as recorded in the Ohio State Medical Journal of July, 1935, page 534.

The Medical Society of New Jersey anticipated the establishment of medical relief in the summer of 1933, by appointing a special advisory committee to consult with the State E. R. A. Council, and to offer a plan for administering the medical phases of the relief. An essential feature of the system that was approved by the State Relief Council was that an E. R. A. committee of physicians in every county should act as an advisory committee to the county administrator, particularly in regard to the bills of the local doctors for their services rendered to persons on relief. The State Committee maintained a close liaison with the County Committees on the one hand, and the State Council on the other. While the broad features of the original agreement have been preserved almost unchanged, the details have been adapted to developments as they occurred, so that the system is accepted as having a high standard of efficiency. The broad outlines of the system were described in the annual reports of the State Committee in the Journals of May, 1934, page 288, and April, 1935, page 216.

THE OHIO PLAN

The Ohio plan allocates a sum of money *each month* for medical relief. One dollar is allowed for each family on relief, and twenty-five cents for each single person. Since there were 264,701 families on relief in April, and 65,718 single persons, a total of $281,130.50 will be available each month at the beginning of the system.

The cost of drugs and medical supplies will be met from other funds supplied by the State.

Each County Director will endeavor to set up an *advisory committee* composed of a physician, a dentist, a nurse, and a pharmacist, after consulting the respective professional organizations of the County. It is expected that the County Committee shall assist in auditing the bills for professional services. It is suggested that provision might be made to pay the medical member a small salary if his services become burdensome.

The adoption of the new system in Ohio is a tacit approval of the system that has been followed for two years in New Jersey.

A similar plan is also in operation in the State of Iowa.

Ergot

A great source of irritation to both the physician and the manufacturer will be removed if experience confirms the reports of the discovery and isolation of the crystalline active principle of ergot by the University of Chicago. The excuse of the manufacturers for the variability of ergot preparations has been the lack of a reliable test for its potency. The blackening of the comb of a domestic fowl to which ergot is fed may not be caused by the same principle that produces contractions of the uterine muscles. The digestion of the extract when it is given by the mouth may give rise to products which are antagonistic to its active principle. Clinical experience confirms the unreliability of the ergot that has been on the market.

The conflicting interpretations of the standards of ergot have led to incriminations among dealers, and to charges of misconduct or incompetency of Federal officers who control the admission of ergot into the United States under the pure food and drugs law. *(Transactions of House of Delegates of The Medical Society of New Jersey, 1934, page 42.)*

The uncertainty will cease if the active principle of ergot can be isolated in crystalline form as the reports indicate (Jour. A. M. A., May 25, 1935, p. 1910). The crystals produce uterine contractions when their solution is injected intramuscularly in doses of 1/150 of a grain. It is earnestly hoped that the product will soon be available to all physicians.

Uniform Stationery

While the *glory* of the Medical Profession is the originality and inventiveness of the individual physicians, its *strength* is in the unity of their aims and methods.

The twenty-one county societies of New Jersey share the responsibilities and the rewards of the State Society of which they are component units, as also they are individual entities in their own right.

A uniformity of the stationery of The Medical Society of New Jersey is a constant reminder to the public of the unity, strength, high ideals and notable achievements of this organization. The officers have purchased a supply of letter paper, each sheet bearing a conspicuous water mark representing the seal of the State Society.

It is planned that the stationery supplied to each officer and committeeman shall be uniform in style, thereby emphasizing the unity of the aims of physicians.

County Societies are offered the opportunity to secure this water-marked stationery of a uniform size and appearance, with the County Society heading printed thereon, at ordinary rates. The stationery will emphasize the County Society, but at the same time the State Society of which it is a component part will appear in the background as sponsor for the local profession.

The new paper is now available to the County Medical Societies through the Executive Offices of the State Medical Society in Trenton.

LeRoy A. Wilkes,
Executive Secretary.

Self-Hospitalization of the Insane

The attitude of the people toward mental hospitals is largely that of fear resulting from ignorance of the nature of mental derangements and of the methods of their cure.

The popular conception of the inmates of a mental disease hospital is that *every* function of their minds is deranged. As a matter of fact, the average patient is deranged in only some one mental function which is essential for maintaining his place in society. He is like an automobile in which a defective spark plug, or a broken cog wheel, or a loose nut puts an otherwise normal car beyond the control of the driver until the one defective part is repaired. Visitors to the hospital are usually surprised to find that a patient who at home was uncoöperative and unreasonable, is calm and talks rationally about his condition and environment, and may even conceal his mental defect. The friends are therefore likely to believe that the patient is the victim of a mistaken diagnosis, and is being mistreated because he is made to conform to the treatment and restrictions of the hospital.

A mental disease hospital is not a place where people generally expect to find examples of happiness or contentment. Yet it is the judgment of hospital superintendents that their patients are happier and more contented than the people of a village of the same population. It is natural that they should be contented and happy, since they are removed from nagging relatives and neighbors, and all their wants are anticipated and supplied.

Some state hospitals send members of their staff to different cities in order to conduct clinics for the benefit of those suffering with "nervous" states; and those patients readily consent to commit themselves to the hospital for more intensive treatment, just as appendicitis patients in a dispensary readily consent to enter a surgical ward for an operation. Over one-quarter of the patients in the State Hospital at Trenton are there voluntarily under the same conditions as patients in a medical or surgical hospital.

A mental condition is most easily treated while it is in an early stage. If physicians would instruct their "nervous" cases regarding the benefits and the attractive features of the State hospitals, patients would apply for entrance during an early stage of their condition when only a short stay would be needed for their recovery.

ORIGINAL ARTICLES

INDICATIONS FOR OPERATIVE INTERVENTION IN DISEASES OF THE STOMACH AND DUODENUM

By George Blackburne, M.D., Newark, N. J.

Read February 26, 1935, before the Surgical Section of the Academy of Medicine of Northern New Jersey

It is obviously impossible to properly present this subject without referring to treatment, and I hereby apologize, if, in my enthusiasm in outlining this subject, I may sometimes stray from the actual title of the paper. Ulcer, and cancer, being the two outstanding pathological conditions encountered in gastric cases, I will merely briefly comment on some of the other conditions, which are occasionally met with, and which demand surgical intervention.

It has been repeatedly stated by myself and others, that foreign bodies that can get into the stomach will, as a rule, pass through the remainder of the alimentary tract. Such foreign objects should be carefully followed by the x-ray, as ulceration may occur from prolonged pressure at the pylorus or in the region of the ileo-cecal valve. An interesting case of an open safety pin swallowed by an infant is reported by Earle.[1] The pin, which was partly caught in the pylorus, was manipulated back into the stomach, after opening the abdomen. The pin was closed, and left in the stomach without opening same. It was recovered in the stools on the fifth day. Another was closed by manipulation through the wall of the stomach and then forced into the end of the small stomach tube, and recovered by withdrawing the tube from the esophagus. If foreign bodies are repeatedly swallowed, they may form a mass that will require a gastrostomy for removal, an instance of which was my own case of a mass of over two hundred safety pins and fibrin, successfully removed and reported at this section.

Phlegmon, a massive infection of the gastric wall, is occasionally encountered. The stomach is found to be dark red, firm, and enormously thickened. It may be of metastatic origin, or be associated with ulcer of carcinoma. The symptoms are severe pain, followed by peritonitis, vomiting and collapse. These cases are most often diagnosed as perforating ulcer or acute pancreatitis, and are only recognized at operation. They are almost all fatal, unless only a limited area be involved, and a prompt resection can be accomplished. It has been suggested, but not been tried as yet, that a jejunostomy be done for feeding purposes, and the entire stomach brought out upon the abdomen wall and treated by multiple incisions down to the mucosa.

Traumatic rupture of the stomach or duodenum has been described, and I have encountered such cases in emergency work. Regarding traumatic ulcer, which is frequently claimed in court, I can find but very slight evidence to substantiate such views, and personally do not believe it is possible. I have so testified in such cases in which I have been called.

Tuberculosis of the stomach, according to Lee,[2] is most common in males, between twenty and forty years of age. It may be mistaken for carcinoma, syphilis, ulcer or benign tumor. Resection is the proper course and the diagnosis is seldom made either clinically or at operation, but is made by the pathologist after a section has been submitted to the laboratory.

Duodenal ileus, according to Rowlands,[3] may be caused by compression of the duodenum by a mobile and loaded right colon and cecum, dragging upon a short mesentery, and also by congenital or acquired adhesions. These cases have attacks of painful distention after eating, occasionally accompanied by nausea and vomiting. The type due to traction is relieved by lying down and elevating the pelvis. Careful x-ray examination will help in the differentiation of these cases from appendicitis, cholecystitis, volvulus of the cecum and ulcer. At operation, these cases show a great dilatation of

the third part of the duodenum. Extreme cases must be treated by duodeno-jejunostomy, anastomasing the first part of the jejunum to the dilated third part of the duodenum. It is Rowland's experience that ulcers, complicating ileus, will usually heal after the above operative procedure.

Diverticula of the duodenum have been identified since the development of gastro-intestinal roentgenology. They are hernias of the mucosa through defects in the musculature. These cases seldom require surgery, unless they produce serious symptoms or endanger the patient's life.

Where immediate attack upon gastric pathology is unjustified, because of the condition of the patient, a jejunostomy may often be used as a palliative measure to tide the patient over a crisis, until a more radical operation is possible. In feeding after a jejunostomy, the surgeons at the Massachusetts General Hospital[5] use a Murphy drip and glucose, lactose, milk, cream, ground meat, eggs, peptonized milk, tomato juice, cod-liver oil and strained vegetables have been found to be well tolerated. The average adult gets three to four liters of fluid, representing three thousand to four thousand calories a day. Should the catheter be withdrawn, it must be replaced promptly. If Witzel technic has been used, upon discontinuing the catheter, the fistula will heal promptly in about three days. H. Hartley[6] gives the details of a small series of gastro-duodenal ulcers cured or improved by simple jejunostomy. After three months of jejunal feeding, if x-ray does not reveal a crater, food by mouth is gradually increased, and then, if no symptoms recur, the tube is removed permanently.

Wilkie[7] states that cases of duodenal ulcer are increasing in numbers. He considers that these cases should be treated medically unless they show stenosis, intractability, repeated hemorrhages or other pathological conditions. It is most important to search for and deal with, at the time of operation, any other associated pathology, providing the condition of the patient warrants it. Prolonged post-operative supervision is essential, with a view of controlling hyperacidity and diminishing the frequency of marginal ulcers. Matthews and Dragstedt,[8] after extensive experimental research, conclude that the chemical action of the gastric secretion seems to be the most important factor in the production of ulcer. While ulcer is most common in young men, a number of cases have been reported in children, and I can recall having seen two in my own experience.

In acute perforating ulcer, x-ray will show the presence of gas in the peritoneal cavity in 75 per cent of the cases. I use this method in diagnosing, and also the technic of dripping water into the wound before opening the peritoneum and watching for bubbles upon nicking it. One must consider gall-bladder disease, coronary thrombosis, tabelic crisis, lead colic and diaphragmatic pleurisy in making a diagnosis. Jiminez[9] advises simple closure in acute perforations. The mortality after operation in the first six hours was only 3 per cent, rapidly rising to 70 per cent after twenty-four hours. My own experience coincides with his views, and it has been the exception for me to have to re-operate on such cases which have had adequate post-operative supervision. Perforations usually give a history of occurring while at work following a meal. I close perforations with a line of sutures running across the lumen, so as not to constrict same but rather to increase the diameter, and then reinforce with an omental rag. These cases, if operated upon early, need not be drained, unless soiling is extensive. Perforations during radioscopic examination have become farly common in recent years.

In the last few years many European surgeons and some Americans have been advocating radical surgery in the treatment of ulcer, but the more conservative methods employed by the average American surgeon seem to be sufficient for the cure or relief of about 90 per cent of the cases. This diversity of opinion became so marked that a commission from the Mayo Clinic met with European surgeons to inquire into the matter, and the conclusion seemed to indicate that the pathological findings were different in the cases seen here and those seen abroad.

H. H. Hurt[10] states that gastro-enterostomy is an old operation that has given good results

in 80 to 90 per cent of cases of peptic ulcer. It protects against fatal hemorrhage. It is palliative in malignancy with obstruction. It is never indicated, however, except in the presence of demonstrable organic disease. It is of no value in ptosis or neurosis. Gaither[11] also defends gastroenterostomy as giving cures or good results in 90 per cent of cases and a very low operative mortality. Benedict[12] states that about 3 per cent of the cases having a gastroenterostomy develop a later jejunal ulcer. In these cases hemorrhage is common. They are likely to adhere to and perforate into the colon. Simple undoing of the anastomosis often cures these cases, but if it does not, we must then do a subtotal gastric resection. In my opinion, the cases cured by an undoing of the anastomosis alone are often those cases in which a gastroenterostomy should not have been done.

Postoperative gastro-jejunal ulcer has a great tendency to bleed. Estes[13] advises disconnection of the gastroenterostomy when the ulcer is small and the original duodenal ulcer is found healed. If the original duodenal ulcer is not healed, then supplement the resection of the marginal ulcer by a pyoroplasty or gastric resection. I can personally attest that this latter procedure is one of the most trying operations that a surgeon is ever called upon to perform, but the results are very satisfactory.

Van Haberer,[14] from the European viewpoint, reviews 3305 cases of gastro-duodenal ulcers and concludes that the best plan is to do a large gastrectomy, with the object of reducing the secreting gastric surfaces and lessening the chances of recurrence. He restores the continuity of bowel by Billroth I or Billroth II. He had an operative mortality of 2-15 per cent due to shock, secondary hemorrhage or cardiac pulmonary complications. He claims that jejunal ulcer does not follow and that over 99 per cent of the surviving cases are cured.

Neuber[15] concludes, as a result of his own experience, that resection of the stomach is necessary for complete cure of gastro-duodenal ulcer. I personally reserve this procedure for intractable cases. I will say in passing that I have heard able general surgeons decline to attempt the procedure in cases of jejunal ulcer secondary to gastrojejunostomy.

Gastric hemorrhage[16] if severe and repeated, demands operation. Such cases are often made better risks by a preliminary blood transfusion. The systolic pressure should never be allowed to fall below seventy, according to Allen.[17] Balfour[18] advises excision of the ulcer with suture and gastroenterostomy at the same sitting. This procedure has been very satisfactory to me.

Benign tumors and polyps often give ulcer symptoms, and excision is indicated, to be made more widely if cancer is suspected. The only hope of lowering the mortality of gastric cancer is in earlier recognition of the condition, and to this end every even slightly suspicious case should be referred to the roentgenologist. In preoperative treatment of cancer cases HCL is advised by Friedrich[19] to help kill off bacteria, and diminish the risk of infection. He gives it three times daily preoperatively, with fruit juice, and washes out the stomach with ¼% sol. just before the resection.

In summarizing, I would say that surgery is indicated in cases where foreign bodies have been swallowed, and have become lodged in the pyloric or ileo-cecal region for a period of several days, in acute perforating ulcer, severe traumatism with suspected rupture, congenital pyloric stenosis, phlegmon, volvulus, tuberculosis, benign tumors, selected cases of duodenal ileus, gastric and duodenal ulcers which have resisted a thorough course of medical treatment, severe repeated hemorrhage, stenosis of one of the orifices, marked deformity of the body of the stomach, persistent postoperative gastrojejunal ulcer, and suspected malignancy.

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PHYSICAL FACTORS IN MENTAL DISEASE

By Julius A. Toren, M.D., State Hospital, Marlboro, N. J.

Read before the Monmouth County Medical Society, May 22, 1935

The physical approach to the psychoses first began to assume concrete form about the year 1918. The State of New Jersey has been in the forefront of this line of endeavor largely through the instrumentality of the late Dr. Henry A. Cotton, formerly Medical Director of the New Jersey State Hospital at Trenton. Dr. Cotton, while studying brain pathology with Alzheimer in Munich, found significant changes in the brain cortex in the psychoses, and one change in particular in dementia praecox wherein the axis cylinder processes of many of the ganglion cells were filled with fat. This led him to the belief that there must be causes outside of brain function itself to bring about these degenerative changes in this commonest member of the so-called functional group of psychoses. It is a direct result of his life work, and the results obtained therefrom that New Jersey has State hospitals equipped with every diagnostic, therapeutic and surgical facility of the general hospital, plus those special facilities necessary in an institution caring for the mentally sick.

PHYSICAL FACTORS IN PSYCHOSES

The theory that physical factors are inherently connected with the psychoses has received support from several directions. First, the relationship between thyroid deficiency and myxedematous psychosis has been conclusively established, as has also the relationship of ovarian states at the involutional period. Second, the discovery of the specific causation of paresis has further supported the theory. Third, the pathological researches of Zingerlie, Alzheimer, Schroeder, and Cotton, subsequently further substantiated by Josephy and Jacob, have, in a manner which it would seem should satisfy anyone, demonstrated a definite cortical pathology in dementia praecox, which has so long been considered to be a functional psychosis. The fatty degeneration of the axis cylinder in dementia praecox, first described by Cotton, is not to be confused with the fatty degeneration of the myelin sheath which is common in the senile.

TOXINS

Another significant change which is often demonstrable is the ameboid degeneration of astrocytes of both gray and white matter which, so far as is known, is produced by agonal or post-mortem autolysis, or the presence of toxins, exogenous or endogenous. Alzheimer states that ameboid degeneration of astrocytes occurs in "infectious delirium, paresis, cerebral syphilis, progressive chorea, acute or subacute experimental intoxication, severe uremia, diabetic coma, sepsis, and in cases where the patient is unconscious for several days before death". Bancroft and Richter have more recently demonstrated definite physico-chemical conditions—changes in the brain colloids—in various of the psychoses. The work of Wolman has shown that changes of a degenerative character occur in neurones as a result of the action of poisons and toxins; that these poisons or toxins may be exogenous, as alcohol, arsenic, lead, strychnine, et cetera, or endogenous, as a result of faulty metabolism, in uremia, or from the action of bacteria as in tetanus, rabies, diphtheria, et cetera. Ferrara's work has demonstrated extensive cortical changes produced in the dog by injection of histamine. The cortical degeneration and destruction of ganglion cells in chronic alcoholism as in Korsakow's syndrome and chronic pseudo-paranoia, as well as the profound histologic and even macroscopic changes in brain structure in senile dementia should lead even the most skeptical to this question: If there are so many cases of psychosis in which actual brain pathology has been demonstrated and where known physical or toxic factors are specifically responsible for the mental derangement, as in hypothyroidism, hyperthyroidism, dysovarism, exogenous and endogenous toxicoses and arterio-sclerosis, is it not possible that physical causes are basic factors in all

psychoses? Is it not a reasonable hypothesis that chronic psychoses bear the same relationship of chronic infections and intoxications that acute hallucinosis, or delirium, bears to the acute toxicoses, except that the latter usually exhibit only disturbances of function while the former have also, by virtue of their chronicity, cortical degeneration as well?

FOCAL INFECTIONS

The presence of physical abnormalities other than anthropological in the psychotic group is so very high as compared with the average members of society that it immediately strikes the attention. Cotton found 3550 abnormal conditions in 500 consecutive cases in the so-called functional group—an average of over seven per patient. Another worker in the field of so-called "focal" or localized infection in the psychotic found that every patient examined had more than one area of involvement. The usual foci and the percentages of their occurrence in his cases were as follows: Alveolar infection, 92 per cent; tonsilar infection, 52 per cent; gastro-intestinal pathology, 42 per cent; uterine infection (women), 90 per cent.

The point to be emphasized is that these patients are really physically ill. Just as most acute infectious diseases gain access to the body through the upper orifices of the body, so also do we find that the principal primary foci of chronic infection are in the head, the teeth and alveolar processes of the jaws, the faucial tonsils, and the accessory sinuses.

PHYSICAL EXAMINATIONS IN MARLBORO HOSPITAL

Our knowledge of the effect of sepsis on brain structure is at the present time only fragmentary. Empirical application of such knowledge as we have in the way of cleaning up chronic septic foci, and the building up of the resistance of the patient by various adjuvant measures, has certainly resulted in greatly increasing the improvement and recovery rate over those which prevail in institutions of the purely custodial type. In this institution, every patient on admission receives, in addition to the taking of the history and the mental examination, a complete physical examination. Because of the frequent incidence of dental and alveolar pathology in mental patients, a full mouth set of x-rays is taken, in addition to a careful examination of the teeth and gum tissues. The laboratory work includes, in every case, a complete blood count; Wassermann; Kahn; blood chemistry determinations, including N. P. N., urea, creatinine, and sugar; examination of the stool for parasites and ova; urine analysis; bacteriological smears from the urethra and cervix in women; bacteriological examination of all exudates, transudates, sputa, oral infections, et cetera, with animal innoculation where indicated. General x-ray work is done on all cases where the physical or laboratory examinations suggest pathology demonstrable by the x-ray; chest pictures for all suspected tubercular cases; G.-I. series, and barium enema, in abdominal cases; head pictures for suspected cranial or intracranial pathology, et cetera.

During the two years ending May 1st, 1935, the following examinations have been made:

Physical examinations	2,105
Dental examinations	6,743
Blood counts	1,043
Blood chemistry determinations	2,410
Wassermann and Kahn	3,213
Spinal fluid (gold curve, cell count globulin, Wassermann)	580
Bacteriological examinations	1,551
Urine analyses	10,555
Feces (for parasites and ova)	790
Feces determination of bacteriological flora	1,725
Dental x-rays	6,487
Chest x-rays	568
Other x-rays	1,070

The following medical and surgical work was done:

Tonsillectomies	166
Other minor surgery	224
Major surgical procedures	137
Dental extractions	6,812
Dental treatments	8,503
For syphilitic patients—	
Intramuscular injections	5,111
Intravenous injections	3,550

There are many medical measures used in selected groups of cases which we have not the time to discuss, such as the induction of hyperpyrexia by malaria or diathermy, prolonged narcosis with some of the newer drugs, et cetera.

The Physiotherapy Department has administered 9,387 treatments, with diathermy 2,114, infra-red 3,620, and ultraviolet 2,188 leading the list. Other forms of physiotherapy administered include baking, massage, copper ionization and sine wave.

As a class, psychotic patients are usually undernourished, and improvement in nutrition is an important factor in the care of the psychotic. As a general proposition, a rise in the weight of the patient is a favorable prognostic sign. Many of these patients suffer from anorexia, and some refuse to eat at all. The former have to be urged to eat, and the latter have to be tube fed. Out-of-door exercise being the greatest stimulant to appetite, outdoor work and recreation is encouraged. The food system in this institution, where all ambulant patients are given their meals on the cafeteria plan in a central dining hall, automatically adds a trip to and from the dining room three times daily, thereby, we believe, aiding appetite appreciably.

Occupation, though we do not always think of it in that light, is one of the great blessings of life. Every patient who is physically able to do so is encouraged to engage in some useful occupation. The farm, the dairy, the hospital grounds engage as many as possible out-of-doors. The serving of food, the laundry, and the cleaning of buildings occupy others. The Occupational Therapy Department with its sewing, basketry, carpentry, rug weaving, et cetera, engages the interest of others who are not able to do more active work.

In this institution we have, fortunately, practically 100 per cent of autopsies in all deaths, including employees. During the two-year period 182 autopsies were performed. Not only is this of a certain amount of scientific value, but it also acts as a stimulus to more accurate and painstaking clinical work. The pathological findings discovered on autopsy were, of course, legion. Certain pathological findings occurred with outstanding frequency, viz: kidney pathology in 100 cases out of the 182 autopsies; organic heart disease in 94 cases; active tuberculosis in 37; healed tuberculosis in 21; pneumonia in 61; intra-cranial hemorrhages in 13; gall-stones in 16; and carcinoma in five. The high incidence of heart and kidney pathology is particularly significant in relation to our theory of streptococcic infection in relation to so-called functional psychoses.

In closing, the thought I wish to leave with you is that we feel the patient with a mental disability is entitled to the same careful physical diagnosis and treatment that he would receive in the general hospital were he entering there for a purely physical disability.

We believe that the raising of the standard of physical and mental well-being by good food, a hygienic and pleasant environment, occupation, hydrotherapy, physiotherapy, suggestive therapeutics, and last but not least, detoxication, all have legitimate places in our armamentarium. But the measure which is essential to bringing recovery to the greatest number is *detoxication.*

PROPHYLAXIS OF MENTAL DISEASE

By Granville L. Jones, M.D., State Hospital, Marlboro, N. J.

Read before the Monmouth County Medical Society, May 22, 1935

The belief that the mind and body are separate entities is no longer valid. Man is a unity of which neither the mind or the body can exist separately, and any alteration of one inevitably affects the other. Not only that, but man is always a part of his environment, and it is impossible to gain a comprehensive knowledge of him without studying it also. In fact, unless we know in general the environmental background of the patient, it is impossible to know that he is mentally diseased. Symptoms that might be grave in a college professor would be insignificant in an illiterate negro. Belief in supernatural events, which in an educated person is almost prima facie evidence of pathology, is more or less normal in a group

of low culture. In short, mental disease is a disease of the *social adjustment,* and may be the effect of physical, intellectual, or emotional changes, either congenital or acquired. The underlying cause is always a conflict between the patient's instinctive desires to live and reproduce, and his conscience or super-ego, which represents society or what society will permit him to do. This being so, we see that we must direct our efforts at prevention toward both the individual and his environment, including both the physical and social features of the latter. However, since it is not feasible to seek out all potential patients, we necessarily work chiefly with social groups, but in doing so we keep our two objectives in mind: We try to spread educational propaganda so that the individual will receive the education in instinctive control we wish him to, and we also try to establish more rational social customs and institutions, with the purpose of making it easier for the individual to adapt his instinctive life to them.

STERILIZATION

Under the measures directed at the patient may be considered the measures of segregation and sterilization. Segregation, perhaps, prevents some new cases, but as a single tool has failed. It has been used for at least a thousand years; still new cases occur.

Sterilization has only lately been proposed, and its real value has yet to be determined. Hitler's grand scheme in Germany, if properly divorced from the Aryan delusion, should be of great value to geneticists. Statistics in this country are of negligible worth, except possibly those from California. The real handicap in applying sterilization intelligently is in our lack of knowledge as to just how mental disease is transmitted. We know it is inherited to some extent but we do not know that it is Mendelian or sex-linked, and if it is, whether it is due to single characters or to multiple, or whether these are recessive or dominant. Myerson has ably defended a thesis that it is a form of cellular degeneracy called by him *blastophthoria,*—an acquired weakness in the germ cells caused by debilitating diseases, alcoholism, or various other toxemias. Certain other authorities,—among them Otto Mohr,—favor sterilization in theory, but object to its general application at present on the grounds that we do not have sufficient data to identify the carriers of defective genes.

I feel that whether or not the diseases are inherited, any patient not completely recovered should be considered as a possible subject for sterilization before release, since no one suffering from a psychosis is fit to care for and rear a child. It is well known that the dangerous years, from a psychiatric standpoint, are the childhood years, and unless it can be demonstrated that someone else will have the care of the child, no psychotic person should be permitted to beget.

A corollary to this is that the Medical Staff here or in any other hospital would release a good many patients more quickly if they knew that parenthood would not be possible. This would relieve the taxpayers of some expense. Also, in a very limited number of cases among women, the fear of pregnancy appears to be a contributing factor, and the removal of this fear would constitute constructive therapy.

VENEREAL DISEASE PREVENTION

It is not only in childhood that preventive medicine can serve the psychiatrist. If syphilis could be abolished, the over-crowding in mental hospitals would be largely eliminated, and a peculiarly distressing form of insanity would be avoided. That is why we are so disgusted with the pious stupidity of many clergymen and school teachers who block efforts to teach sex hygiene of a rational sort to young people. The traditional chamber-of-horrors lecture to Boy Scouts and Y. M. C. A. classes, with the stress on phagedenic ulcers, buboes, and balanitis probably reduces the incidence of paresis, but increases the occurrence of dementia praecox. A recent development in the technic of fever therapy is worth mentioning: It is now believed that treatment of early luetics with artificial fevers will protect those patients from later developing syphilis of the nervous system. Time will be necessary to determine this.

GENERAL MEASURES OF PREVENTION

In other fields of preventive medicine there are specific ways of affecting the occurrence of

mental disease. I may mention control of industrial toxins, pellagra, alcoholism, and drug addiction. The general field of prevention of epidemic diseases includes the vitally important problems of meningitis and encephalitis. The present increase in traumatic injures, particularly of the head, is making it necessary for the entire profession to be familiar with methods of treatment of these conditions. While the importance of head trauma in producing mental disease is vastly exaggerated by the laity, traumatic psychoses do occur. They may often be prevented by proper treatment, particularly by avoiding compression through adequate drainage.

ENDOCRINES

Endocrinology is a promising field from the psychiatric as well as from the general medical standpoint. Particularly is this true in the involutional psychoses, in thyroid dysfunctions, and in the rather vague group of juveniles classed as the hypoplastics,—the pluriglandular dyscrasias in which the subject is so handicapped physically that he cannot take part in normal athletics and social activities, and so develops a narrow field of interest and a distorted personality. With the unprecedented amount of research in endocrinology it is hoped that we shall soon have satisfactory therapy for this and allied conditions.

The normal life is happy and useful, and a child is not educated properly until he knows how to live as well as make a living. To achieve true happiness the individual must learn to accept reality and not ignore unpleasant and painful situations. It is easier at the time to evade and "kid" one's self, but this leads only to accumulative trouble which may become intolerable. The sane, wholesome life is one in which grief, disappointments, fear, and frustrations are met courageously and either solved or accepted as inevitable.

ORGANIZATIONS

To go into details as to practical measures would take too much time. The machinery which has been devised to put them into effect can be briefly mentioned. The most important agency is the *National Committee for Mental Hygiene*.

The smaller units are the mental hygiene, child guidance and psychiatric clinics, mostly sponsored by State and local governments. By tradition the responsibility for mental health has always been more or less left to governing bodies. This is due to the relative lack of specialists, particularly in less populous sections, and to the legal aspects of institutional treatment. However, the policy of the State of New Jersey is to encourage local participation, and to require payment for care where possible.

THE FAMILY DOCTOR

Private practitioners can and do render much service. If the general medical men would inform themselves in mental medicine, there would not be the tendency among social service groups to steer so many potential pay cases to the state supported clinics. However, the usual story is that patients with neuroses or even psychoses have been laughed at and told, "It is only your state of mind." While that may be strictly true, there is no comfort for the patient in such an attitude. Equally disastrous for both the patient and the physician is the all-too-common practice of attempting to cut out hysterical symptoms or to cure them by diets, tonics or barbituric sedatives. We trust that the tendency today to devote more time in the medical curriculum to psychological medicine will correct some of these evils.

There is much of tremendous significance to psychiatrists in the social economic movements of today. As I mentioned, a conflict between the instinctive wishes and the social standards as construed by the individual is the cause of mental disease. The trend today is toward a more paternalistic form of government, and toward a more liberal attitude toward religious and moral problems; and one may expect lessening of the tension in the individual. At any rate, it is not unreasonable to believe that the elimination of the fear of poverty and dependence and the change of sexual problems from the field of morals to the field of psychology and sociology, should make a difference in the symptomatology and perhaps the incidence of mental disease.

PRACTICAL SUGGESTIONS FOR THE MANAGEMENT OF CERTAIN EAR, NOSE AND THROAT CONDITIONS

By John R. Page, M.D.,
Surgeon Director, Manhattan Eye, Ear and Throat Hospital, New York, N. Y.
Read before the Atlantic County Medical Society at Atlantic City, April 12, 1935

The care of acute middle ear inflammation is a matter of practical importance to the general practitioner and pediatrician as well as to the otologist. Difference of opinion still exists regarding it, but to a less extent than formerly, and facts demonstrated during the past year will, I think, tend to make still further agreement probable.

PARACENTESIS OF THE EAR DRUM

Dr. Dwyer in a symposium on respiratory infections renews our interest in some acute catarrhal types by calling attention again to the bad effect on hearing from repeated occurrence of negative pressure and the exudate of fluid in the middle ear. Occurring as this does without pain or fever, the exudate is left to be absorbed or to be discharged through a swollen eustachian tube. We are all familiar with these cases and find that they occur in some children and young adults in spite of the removal of tonsils and adenoids and the usual treatment of the nose and throat. Many resolve spontaneously, but on the whole hearing is probably better preserved in the majority of them when their drums are opened. Whether opened by a small paracentesis or a wide myringotomy, depends on the type of case involved. I will be criticized by those who claim that such cases are more often infected and made worse than they are helped by early paracentesis, although this claim has not been substantiated by clinical statistics.

On the other hand, the advisability of early paracentesis or myringotomy in acute middle ear infection was recently shown at the Manhattan Eye, Ear and Throat Hospital in three hundred cases which were divided into discharging and non-discharging ears. In these it was found that nearly three times as many mastoid operations became necessary among those whose drums ruptured as among those who had them opened before rupture occurred. It is sometimes argued that these drums with little or no fluid in them, no fever, and no pain, are not infected, but the cultures taken in such cases show that the majority of them are. Harm rarely comes from a paracentesis properly performed, and deafness is relieved that otherwise might persist for weeks when fluid is left to become absorbed.

INFECTING ORGANISMS

Some further information was gained regarding the significance of the infecting organisms when last year cultures were taken on all the acute middle ear abscesses that were sent in for myringotomy from the different ear clinics of the Manhattan Eye, Ear and Throat Hospital. This was done for the purpose of determining as far as possible their prevalence at the different seasons of the year, and their relative virulence.

The result for the year was that fifteen different types of infection were found in 836 cases. The hemolytic streptococcus was the most prevalent at all seasons of the year (30.1 per cent) and was the cause of the most mastoid operations. 7.9 per cent of the middle ears infected by it required operations on the mastoid. The pneumococcus, type III. was next in prevalence during the Winter months, and for the year it tied for second place with the staphlyococcus aureus. It was the most virulent of the infections, and 11.1 per cent of those infected by it required operation on the mastoid.

Mastoidectomies were necessary in but four of the fifteen different infections, which indicates some prognostic value to cultures taken at myringotomy. They were confined to the hemolytic streptociccus (7.9 per cent) the pneumococcus type III. (11.1 per cent), the staphylococcus aureus (4.2 per cent), and there was one in nineteen staphlycoccus albus infections, the significance of which is doubtful. None occurred in 52 hemolytic staphylococcus infections. It is difficult to explain, except

as the result of faulty technique, the 185 cases from which no growth of bacteria was obtained, and four in this group that had sterile cultures.

These findings are different from those of Dean, Hadjopoulos, and others who have found the pneumococcus type III. less prevalent and much more destructive than this report shows. Its presence in an acute middle ear abscess has been thought by some to warrant immediate operation on the mastoid. But, as this series shows, mastoid involvement seems to depend not so much on the virulence of the infecting organisms as on the resistance of the body to it, and on the anatomy of the mastoid which in some instances tends to retain, and in others to expel infection. The danger from the pneumococcus type III. infection, nevertheless, should not be minimized, for although it is not as universally destructive in the mastoid as it has been reported to be, it occurs next in frequency to the hemolytic strepticoccus as the infecting organism. A higher percentage of mastoid operations develop from it than from any other organism. Some practical value may be gained from this report if it encourages otologists and pediatricians to take cultures from the knife after they have incised or punctured a drum, and to put to bed under especial care those cases that have hemolytic streptococcus and pneumococcus type III. infections.

INDICATIONS FOR OPERATION

Little difference of opinion exists regarding the indications for operation on the painful, fulminating type of mastoid infection, but this is not so in cases in which pain, tenderness and fever have ceased to be conspicuous symptoms shortly after the onset.

Those who hold back in operating on the latter class may tend to operate too early on the former. Many "green mastoids" have been opened because of high temperature, pain and tenderness, or the presence of pneumococcus type III. infection when they might have been given time for local resistance to the infection to become more established and the mastoid and innner plate less brittle.

Dr. Whiting thought a case of mastoiditis was rarely ever ready for operation under a week's time,—which is a good rule to follow if one realizes that there can be now and then a rare exception. Three such exceptions have occurred that I know of in thirty years. Two of the cases were definitely pneumococcus type III. infections, and the third may have been. All developed advanced lateral sinus thrombosis in under a week's time from the beginning of the middle ear infection, the last case in less than five days from the first sign of middle ear infection.

PETROSITIS

In reference to *petrositis*, these seems to be three kinds, those that occur with acute mastoid infections in pneumatic bone; those that occur in chronic suppurative cases with or without dead labyrinths; and those that follow severe involvement of the sphenoidal sinuses and have what Dwyer says is essentially osteomyelitis of the base of the skull. In speaking of infections of the middle ear and mastoid, he says most infections probably travel through the eustachian tube, but that a larger percentage than we think travel through the blood or the lymphatics and produce a different pathology. Instead of mastoiditis through the usual tubo-tympanic path to the mastoid process, he thinks we may get an invasion from the sphenoid, or from tissue around the eustachian tube, and develop an osteomyelitis of the base of the skull, and only secondarily an invasion of the mastoid process proper. This may occur as a thrombo-phlebitis leading to an osteomyelitis. The pathway may be from the sphenoid to the petrous bone and not from the mastoid process proper. He thinks this explains some of the fatal cases of so-called mastoiditis, operated upon as ordinary mastoiditis, but which is essentially an osteomyelitis of the base of the skull, the petrous bone, and the mastoid.

It also explains, he says, the difference of opinion among otologists in reference to the pathology of the petrous bone. Some claim that we have to have a pneumatic mastoid with cells leading to the petrous tip in order to produce a lesion of the petrous. Others claim that it is an osteomyelitic process and that the path

is not necessarily from an infection in the mastoid. He performed autopsies in two cases of meningitis, in which he could demonstrate that it was undoubtedly an osteomyelitic process, doomed from the start, as such lesions along the base are not amenable to surgery in this region and tend to go to a fatal issue. I have not seen enough autopsies on cases of mastoiditis and sinusitis where it was found that the mastoid and tympanum and petrous pyramid and sphenoidal sinuses were all involved to make me feel assured in any case that the infection passed from the sphenoid to the petrous and thence to the tympanum and mastoid, as Dr. Dwyer states. It is reasonable to think it may possibly occur; but I think the pan-sinusitis, otitis media, and mastoiditis are more likely to develop through different pathways from the same infection in the nasopharynx. I have seen such a case as Dr. Dwyer described as essentially an osteomyelitis of the base of the skull, where every bone was involved, even the basillar process of the occipital bone, and the condyles at the base of the skull. In such a case, however, I think if the infection of the bone at the apex of the petrous came from the sphenoid it was met more than half way in the pyramid by infection from the middle ear and mastoid that came up through the eustachian tube.

The type which is found in cases that have already been operated upon for acute mastoiditis is not, owing to incomplete mastoid surgery, so rare. When the deeper cells in the base of the pyramid are more generally removed during the operation for acute mastoiditis, this type will be less often seen.

Not so long ago, many otologists discountenanced interference with even the lining membrane of the mastoid antrum, much less the cells around and beyond the semicircular canals. Since then it has become more generally the practice to look for softened structure in this region and follow it to its depth which may explain the fact that men whose technic is particularly thorough in this respect tell me they rarely see complications at the petrous apex.

SUMMARY

In conclusion, let me emphasize the value of early myringotomy to let out infection before it becomes established, and the prognostic value of cultures properly taken at that time; the importance of daily inspection of the drum membrane to watch for widening perforations, particularly in babies and young children, as well as signs of deep involvement in the mastoid; the frequent absence of mastoid tenderness and fever in cases that show other signs of well developed mastoiditis; and the insidious progress of infection in the mastoid in many cases which makes precautions necessary in all cases of acute middle ear infection until they are proven to be mild.

INTESTINAL OBSTRUCTION

By Arthur M. Wright, M.D., New York City

Abstract of a paper presented before the Hudson County Medical Society April 2, 1935

Acute intestinal obstruction is a surgical complex that holds the unenviable reputation of carrying the highest immediate mortality in the surgical realm,—40 to 60 per cent. This high mortality has not been reduced in the past 50 years.

In Bellevue Hospital 665 cases have been operated upon in the past 14 years with a mortality rate of 46.7 per cent. The mortality rate is influenced by the following factors:

1. Location of obstruction,—the higher the obstruction the higher the mortality.
2. Type of obstruction,—less in strangulated external hernia than in strangulation by bands.
3. Length of bowel involved.
4. Directly proportioned to age.
5. Most important, the duration (in hours) of the obstruction before operation.

Uncomplicated intestinal obstruction is a

relatively rare condition. Intestinal strangulation is the condition with which the surgeon must cope at the time of operation. For the sake of emphatic instruction, it might be well if teachers in our medical schools would minimize or possibly discard the word *obstruction* and substitute for it the word *strangulation*. Obstruction connotes little. Strangulation is the crux of the problem.

The pathology is divided into three stages:

1. Congestive and exudative;
2. Toxic or infective;
3. Peritonitis.

The causes of death in acute intestinal obstruction plus strangulation are varying combinations of dehydration, shock and toxemia, the preponderance of one over the other being influenced by:

1. Location of the strangulation;
2. Degree of occlusion of the blood vessel;
3. Length of bowel involved.

The pathological changes in true functional obstruction differ from those of mechanical obstruction only in the initial stage. Because of the accumulation of fluid and gas within the lumen of the gut, kinks form and true multiple mechanical obstruction develops, this corresponding in a general way to strangulation of a long loop of intestines. The pathological changes are slower, yet the effect is equally rapid because of the greater length of bowel involved.

Symptomatology:

1. Peristaltic pain;
2. Vomiting;
3. Obstipation;
4. Intestinal distention.

No disease has symptoms more unmasked. They are definite, strikingly unmistakable and accurately indicative of the underlying casual pathology.

DIAGNOSIS

It would seem that this is a disease which would be attacked early. However, relatively few patients are operated upon during the first twelve hours, when the mortality is 20 per cent or less. In a case of suspected intestinal obstruction a systematic examination is recommended.

1. Look for external hernia and abdominal scars. These two (external hernia and previous laparotomies) are responsible for 75 per cent of all cases of intestinal obstruction.
2. Rectal examination for malignancy.
3. Look for classical symptoms of intussception (pain, vomiting, sausage shape mass, bloody stool) in children under 10 years.
4. X-rays taken in horizontal and upright positions on all doubtful cases.

TREATMENT, PRE-OPERATIVE

1. Replace as much body fluids and salts as time permits. All cases should receive at least 1000 c.c. normal saline intravenously before operation; and when acetone is present in the urines 5 per cent glucose should be added to the saline.

OPERATION

The surgical procedure adopted depends on the individual case. Two paramount objectives must be borne in mind at every operation.

1. Release the obstruction when possible.
2. Decompression of the gut. An internal ileostomy (enteroenterostomy) is preferable to an outside ileostomy. More extensive procedures must depend entirely on the problems of the individual case.

Statistical results favor no particular procedure. The simple ileostomy carries as high an ultimate mortality as radical resection.

POST OPERATIVE TREATMENT

All efforts should be directed against toxemia and dehydration. Dehydration and its associated derangements may be successfully combated by replacement of fluids, salt and glucose. These should be given parentially by infusion, clysis and rectally.

Distention of the stomach should be anticipated by passing a small tube (Levine type) through the nose into the stomach. A continuous suction apparatus attached to the tube augments its usefullness.

Morphine (¼ gr. every 4 hours) for at least 48 hours gives the patient much needed rest. Posterior pituitary extract has been beneficial.

TREATMENT OF RINGWORM OF THE FEET

By C. C. Carpenter, M.D., Summit, N. J.

Read before the Summit Medical Group, January 8, 1935

The approach of hot weather will cause a large increase in the number of individuals suffering from ringworm infection of the feet. This increase may be accounted for by the many persons who will be exposed at public beaches, bathing pools, and showers; and also by the more active growth of fungi under conditions of heat and moisture.

For this reason it is well to consider recent modes of treatment that have been found of value, as well as to evaluate other means that have been popular in the past.

TREATMENT OF UNCOMPLICATED INFECTIONS

Classified under this heading are those cases of superficial infection that begin as a white, scaley, slightly itchey eruption found most frequently in the fourth interdigital space. Occasionally a small fissure may be present, and if vesicles are observed, they are thin walled and apparently lie right at the surface.

These are the early cases for which so much can be done by local medication. The most popular of these medicaments include salicylic acid, benzoic acid, thymol, hexylerosorcinol, Absorbine, Jr.; sodium hyposulphite, sodium hyperchlorite, merthiolate, Metaphen, Mercuric chloride, and iodine. Many of these are used singly or in combinaton to form ointments, "creams", or lotions. Such an extensive armamentarium tends to produce much confusion and the selection of what is best becomes a wearisome procedure of trial and error.

Recent investigations at the University of California[1] have given some very interesting results on the use of these different preparations not only on spore cultures of fungi, but also after the immersion of infected scales in solutions of these remedies. Their results would indicate that the inhibiting effects of sodium hyposulphite, Absorbine, Jr., and Metaphen were practically nil. On the other hand, salicylic acid, thymol, benzoic acid, hexylresorcinol, and sodium hypochlorite were of distinct value when used in concentrations that are not harmful to the normal skin. The most efficient of all were iodine and merthiolate.

It would seem wise then in selecting a mode of treatment to first try those that are well proven for their fungicide properties. Tinctures and solutions of merthiolate and iodine alone may be sufficient, but in most cases a keratolytic agent is needed to remove the excessive "horny" layer as the mycelia of the fungi lie beneath this. Whitfield's ointment is one that will do this and at the same time has some fungicidal properties. Better results are, however, obtained if this ointment is combined with paintings of dilute tincture of iodine or tincture of merthiolate. Strickler[2] has advocated the use of the following prescription:

Rx.	Iodine Crystals	1.3
	Potassium Iodide	1.9
	Salicylic Acid	1.9
	Boric Acid	3.8
	Alcohol 50% to make.	59.1

Theoretically it is correct for this dermatoses, as it combines an active fungicidal reagent with a keratolytic. This prescription is very similar to one that I was introduced to in Hawaii five years ago, and have used with practically constant success since that time. Its formula is as follows:

Rx.	Iodine Crystals	1.0
	Salicylic Acid	3.0
	Ol. Ricini	10.0
	Alcohol qs	30.0

The amount of iodine may be varied to suit the individual's skin, and the salicylic acid increased or decreased depending upon the keratolytic effect desired.

The following cases will illustrate the method of using this solution:

Case 1. White male, aged 25, has had an itching eruption in the fourth interdigital spaces of both feet for the past six years, which became aggravated each summer, at which times he could remove mascerated, thick, white scales from these

locations. He was placed on the above formula with instructions to paint the toes each night for five days. At the end of this time the thickened, mascerated epithelium had peeled off, itching had stopped and the patient was discharged.

Case 2. White male, aged 48, complaining of "peeling" between toes for past several years. A mild scaling dermatitis was present in the fourth interdigital space. There was also a mild involvement of the toenails. In both of these areas mycelia were recovered by culture. He was placed on the above formula for six nights and was discharged very much improved at the end of this time. There was a recurrence six months later, as he had failed to follow the prophylactic instructions given. The use of this solution for seven nights cleared up this remission.

Case 3. White male, aged 38, had had an eruption in the third and fourth interdigital spaces for the past three months. He had contracted this trouble while vacationing at the shore. There was a very adherent layer of white, soggy epithelium in these locations. For five nights he painted his feet with the above solution, which helped the itch but apparently made no impression on the thickened layer of epithelium. The strength of the solution was increased to six per cent iodine crystals and twelve per cent salicylic acid, with instructions to confine this solution to the affected areas. After six nights of this treatment the thickened layer peeled away leaving a normal area of skin which showed no evidence of ringworm involvement.

TREATMENT OF COMPLICATED INFECTIONS

By the complicated case of ringworm of the feet, I refer to those that have progressed beyond the mild inflammatory state and are beginning to show ezcematous changes on the dorsal surfaces of the toes and plantar surfaces of the feet. There may be many deep large vesicles, or pustules, much exudation of serum, and usually an intense burning and itching.

Such cases need primarily soothing treatment, and in my experience nothing has proved as rapid or efficient as fractional x-ray therapy. It almost immediately relieves the intense pruritis and the large vesicles rapidly melt away under its use. Wet dressings of aluminum acetate or boric acid may be combined with this treatment or the use of soothing lotions and bland ointments. The use of trichophytin extract in this condition is still a question,[3] but it has been my practice to use gradually increasing dosages by the intracutaneous method.

After the subsidence of the acute phase, recourse should be had to the same treatment as used in the uncomplicated cases.

These case reports will illustrate the mode of procedure in these complicated infections.

Case 1. White male, aged 30, had a weeping, vesicular eruption on the dorsums of both feet, the plantar surfaces of the toes, and interdigital scaling with maceration. This condition had been present for three weeks, during which time there had been a great deal of itching. A superficial x-ray treatment of one-quarter unit was given, and the patient was instructed to soak his feet in a one per cent solution of aluminum acetate. Three days later there had been a marked improvement and he was given an eighth unit of superficial x-ray therapy, with instructions to continue the wet dressings. At the end of the week the vesicles had disappeared and the epithelium had grown over the previously denuded and weeping areas, and he was switched to Lassars paste. Four days later treatment was commenced to eradicate any remaining fungi that might be present. The solution, containing iodine, salicylic acid, castor oil and alcohol, was used in a very dilute state at first, and during the next ten days was gradually increased to its full strength, at which time the patient was discharged as cured.

Case 2. White male, aged 27, had for the past several years recurring attacks of vesicular, weeping eruptions on the hands and feet. The present attack had been of two weeks' duration and he presented many grouped deep vesicles on the bottoms of both feet that were intensely pruritic. In addition, there was interdigital scaling, fissuring and a superficial involvement of the toenails. A superficial x-ray treatment of ⅜ of a unit was given, and he was told to keep his feet constantly immersed in a saturated solution of boric acid. Within a week the majority of vesicles had disappeared, itching had ceased, and he was asked to use the iodine salicylic acid, castor oil, alcohol mixture during the next week. At the end of this time the feet were entirely well, and scrappings taken from the interdigital spaces showed no fungi on microscopic examination.

Case 3. White male, aged 45, had developed during the preceding week an eruption on the foot and also in the groin. In both regions there were the typical signs of a mild ringworm eruption, and fungi could be found in both locations by the use of the microscope. The iodine solution was used in both localities with great effectiveness during the next week. Every second day an intradermal injection of 0.1 c.c. of trichophytin extract was given, starting with a dilution of 1:50 and increasing to 1:10. Within twenty-four hours following the last injection there was a severe local reaction and the toes and plantar surfaces of the feet were covered with large vesicles which broke, leaving a raw, denuded surface. A superficial x-ray treatment of one-half unit was given to the feet and he was instructed to soak his feet constantly in aluminum acetate. Within four days the vesicles and weeping had disappeared, and he was put on a soothing ointment. This case illustrated the possibility of disturbing a patient's normal resistive balance by too intensive treatment.

PREVENTION OF RECURRENCES

It is sometimes difficult to evaluate whether the patient has been reinfected or is suffering from a recurrence due to the spread of the infection from some insufficiently treated foci. Of prime importance then is the necessity of searching out all possible nidus on the feet which may cause trouble in the future. Search should always commence with the nails, as investigators have shown[4] that if there is involvement of these structures, the interdigital spaces may again become infected. Recently it has been shown[5] that treatment should extend on the normal skin for at least an inch or two inches surrounding the affected zone, for in this area mycelia have been found extending through the apparently unaffected skin.

PROPHYLAXSIS

The use of sodium thiosulphate as a foot-bath[6] has become so popular that it is difficult to disregard its use because of adverse criticism[1] concerning its fungicidal powers. It would seem better to use sodium hypochlorite in a one per cent solution or Chlorax in a 1:5000 dilution. The feet should be immersed in such a solution for five minutes following exposure at any public bathing place. In addition susceptible individuals should make a practise of never walking barefooted around their homes, as carpeting may act as a source of reinfection. Slippers that have been worn during an active infection should be discarded and new ones secured. Bed linen, towels, and socks should be boiled rather than dry cleaned, as kerosene even in full strength[1] has shown no fungicidal properties.

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MOSES MAIMONIDES THE PHYSICIAN

By EDWARD J. ILL, M.D., Newark, N. J.

Delivered at the Celebration of the 800th Anniversary of the Birth of Moses Maimonides, held in the Academy of Medicine of Northern New Jersey on the evening of June 4, 1935, under the auspices of the Maimonides Medical League

When I was asked to deliver a short paper on Maimonides as a physician, I readily consented, for I learned that others were to speak on other attributes of this great man, and much new information was in store for me. It has given me particular pleasure for many years to collect information regarding Maimonides. I first learned of him when I received a copy of the works of the great Arabian physician Avicenna, which you will find in the anteroom of this building. Since then I have been increasingly interested in this man.

Maimonides, like all other great scholars of the Middle Ages, was well versed in the literature relating to all sides of man's nature, the physical, the mental and the moral, represented by medicine, philosophy, and theology. He was intensely practical in his application of all these three branches of learning. As a practicing physician, he was so renowned that the Arab poet, Al-Said-Ibn Surat, wrote:

"Galen's art heals the body,
But Maimonides' the body and soul.
With his wisdom he could heal the sickness of ignorance.
If the moon would submit to his art, he could cure her of her periodic defects."

Maimonides was equally practical in his philosophy and theology, as is shown by the following quotation:

"The eighth (degree of charity) and most interesting of all is to anticipate charity by preventing poverty. This is the highest step and the summit of charity's golden ladder."

In 1920, I read a paper before the Fortnightly Club on the "Cultural Influence of the

Jew in the Middle Ages". At that time, I said:

"Maimonides was a physician, theologist, and philosopher whose work laid the foundation of Jewish mental efforts for many centuries to come, and whose philosophy was the cornerstone of all philosophers down to the present day.

"Not only that, but he seems to have influenced William of Auverge, Bishop of Paris (1228); Albertus Magnus (1193) (one of whose works you will find in the anteroom of this hall), and Thomas Aquinas (1225) in their religious thoughts. Pope Leo XIII declared that the Summae Theologae—i. e., the sum of theological knowledge of these three—was authoritive. Most likely these three great teachers were influenced by Maimonides' book on 'The Guide to the Perplexed'."

I repeat this because I want you to know that what I have learned of this great man has not been gathered today, but is the result of observation and reading of many years.

It is of interest to know how often the works of this man have been published in the following centuries. Of course, when printing was discovered, we find that the Fifteenth Century was not slow in noting his valuable work in medicine. His books appeared not only in Hebrew but in Latin, Greek and Arabian at that time.

There is a time in the lives of every people when some great physician steps to the front and holds the attention of our profession for centuries. Thus we have Malpighi among the Italians, Louis among the French, Lister and Sydenham among the English, Vesalius among the Dutch, Virchow among the Germans, and Osler and Welsch among our own people. When we go back into the history of the distant past, Maimonides is outstanding in the Middle Ages and Hippocrates during the heighth of Greek civilization. It is remarkable that all these men were not only great physicians, but men of high moral attainments. It is rather difficult to imagine a good doctor except with a high sense of ethical responsibility. In these men I have just spoken of, this responsibility has been paramount. It would not be right to say that during these many years in which I have met physicians that I did not find this characteristic predominent. It is from the moral philosophy of such men like Maimonides that we have been saturated with this responsibility. I do not have to tell you that in the days of old, Medicine, Philosophy, and Religion were closely interwoven.

With the knowledge of medicine at a low ebb, I suppose it had to be so. But these men, laboring under such great disadvantage, did a world of good. Thus Maimonides helped to dispel the mysticism and the superstitions of former ages, and put in its place observation and rational medicine.

When we consider that more than ninety per cent of the sick get well by simple advise as to sanitation and mode of living, we can well understand why Maimonides was so great a physician. He ever had this knowledge impressed on his patient. Nevertheless, how often Maimonides must have been perplexed with his patients is known only by those of today who are constantly repeating to themselves, "If I only knew what I do not know, how much I would know."

Owing to Maimonides and his teacher Averroe, there was a movement of rationalism, which only several centuries later became an important matter in the free and independent scientific studies in the occidental universities.

Of course Maimonides had his opposition. He was told that health and disease were in the hands of God and must not be interfered with by man. Within a century the doctors were told that the throes of maternity must not be lessened, because God had decreed that women must suffer in travail. History also tells us that he had his trouble with what we call Christian Scientists. History ever repeats itself. I am sure that Maimonides was no anti-vivisectionist, for we learn that "there is no animal from the elephant to the worm that has not been created for man's sake". Nor was Maimonides a prohibitionist, but he surely advised temperance in the use of alcoholics. He says it is not wise for the young to take wine. What would he say if he heard of five o'clock cocktails? I know positively what he would say. He would say exactly what I have

in mind and he would in spirit shake me by the hand.

We learn of him that the physician who is conscientious and well trained is a holy servant of God. To this we say "Amen".

He also tells us, "We always must be ready for new ideas." I should like to add to this, "with a critical mind". It is surprising that a man of his personal habits should strongly advse physical exercise as conducive to health. But then it is rather hard to know of his personal habits except that the immense amount of mental work must have prevented any regular or extensive physical exertions. Maimonides says that the "art of healing is so vast". What would he say when today no doctor's vocabulary is sufficient to express all the new things, and no one reads a medical article unless he has a dictionary at his side. In his daily prayer, Maimonides asks God to preserve his strength that he may be able to look after the rich and the poor, the friend and the foe. What would he say if he learned that at this time there is a hospital for the rich, and another for the poor, and none for the middle class? On the other hand, one cannot but respect his eighth degree of charity as given by this learned man to help the troubled to help himself.

Maimonides' modesty is worthy of our serious consideration, for he says:

"Do not think that I consider myself the only man to whom you may entrust the care of your health. Indeed, there are more capable physicians than I in this very city. But I know my limitations far better than I know the limitations of others. Therefore, I prefer to trust my own judgment as against the advice of the more skillful doctors."

When we look up the medical history of Maimonides, we are surprised at the many efficient and useful suggestions he makes on disease. Remember he had neither chemistry, nor the microscope, neither the physicists, nor a good mechanic at his disposal.

With his high attainments, it is no wonder that his services were requested by the great of his day. At times, this call was not to his taste, and he begged to be excused. Later, he did become the physician of Saladin the Great for whom he wrote a letter on dietetics, in which in his way he followed the teaching of Hippocrates. Within a year a writer published Hippocrates.

Within a year, a writer published a book on the history of Saladin the Great in which he did not speak of Maimonides though in the preface he said there was not much more to learn of this great Sultan. I had his attention drawn to this deficiency, much to his chagrin. I wanted the doctor given his due.

Maimonides evidently was preëminent in toxicology, the branch of medicine that treats of poisons. He wrote a book on "Poisons and Their Cures" in 1198. In his instructions on the poisons, he cleverly divides the subject into the poisons of animals, mad dogs, the snake, the scorpion, etc.; then of the poisons of plants, Hyoscyamus and poisonous mushrooms; and lastly poisons of the human bite. About the last, he remarks that "the bite of him who is not drunk is most dangerous". I do not know why that is, unless the biter has disinfected his mouth with alcohol in its various forms. Wine has always been used by the ancients as a disinfectant. Alcohol had not been known at that time as a beverage, if I am rightly informed. The wine of the hot countries contains eighteen per cent of alcohol, and is an efficient disinfectant.

He speaks of the prophylaxis of the internal poisons, whether real or suspected, and their remedies. As one reads these instructions, one cannot but regard the advice as extremely rational. Poison wounds are treated by the ligatues of the limb above the wound. He advises wounds to be sucked out either with the mouth or a cupping cup. If the mouth is used, the lips should be covered with oil, and the mouth rinsed with wine. The wound is kept open for drainage. What better could we ask the laity to do even at this late day?

Maimonides' medical works were mostly written in Arabian, for the language of the country was that. The teaching of poisons and their cures must have been a most important subject for the physicians of those days, for we all know of the prevalence of the crime by poisoning in the Middle Ages.

That the ordinary man would understand,

he gave instructions in first aid in such cases, recognizing that procrastination would be fatal. His great learning and capacity for work is shown from the fact that he published a book on the truths of the doctrines of Hippocrates. Another work appeared on the knowledge and treatment of hemorroids. This condition gave the physician of his day much annoyance and was a great puzzle. The Old Testament is constantly speaking of this disease. He translated into Hebrew the works of Avicenna, which in itself was a great undertaking. His finest work, however, was on the causes and symptoms of disease.

We know that phthisis and other diseases of the lungs were not unknown to him even in a pathological sense. A most interesting fact is that he had a strong suspicion that criminality is the cause of a diseased mind. This condition was made a real study by the medical profession during the past fifty years only. Unfortunately all of his works on medicine have not been translated, which his biographers, as it seems to me, should have done.

It has been rather difficult for me to express in words the achievements of Maimonides. Words often enough fail to express the great respect we have for original workers. It would be well for the present-day medical profession to study such characters as Maimonides and thus get peace of mind, if not peace of body.

Much is to be learned in the history of medicine, for the history of medicine is the history of the human race.

To be remembered by one's profession for high attainments is of greater honor than to have one's bust carved in stone or cast in bronze.

MAIMONIDES IN THE WORLD OF PHILOSOPHY AND METAPHYSICS

By Rabbi Leon S. Lang, Newark, N. J.

Abstract of an address at the 800th Anniversary of the Birth of Moses Maimonides, held in the Academy of Medicine of Northern New Jersey, on the evening of June 4, 1935, under the auspices of the Maimonides Medical League

Maimonides was essentially a rationalist, who at the same time clung tenaciously to the traditional religious concepts which he considered basic and indispensable to the Jewish religion. His metaphysics consisted largely of reconciling the thought of Aristotle with the revealed faith reflected in the Bible. His method was therefore largely that of interpreting and illuminating passages in the Penteteuch, to prove that no essential contradictions existed between true philosophy and true religion. The candor with which Maimonides approached problems of philosophy and religion, and his generally healthy outlook, are in themselves refreshing and challenging, and worthy of our thoughtful attention.

What is furthermore noteworthy in the thought of Maimonides is his progressive social outlook, even in the process of developing his metaphysics. To be sure, the perfection of life is to be attained in contemplation of the profound truths of the nature of God and of the Universe. However, the luxury of this preoccupation Maimonides recognized as attainable only after a communnity had developed social security and harmony to such an extent that it permitted the peace of mind and necessary comforts of the body prerequisite to the fulfillment of this highest purpose of life.

He emphasized the continuous dependence of individuals upon society, and therefore the obvious obligation of every human being to contribute toward the strengthening of the social community. He viewed social institutions as instruments by means of which the most noble personal living became possible. The full purport of such a viewpoint becomes especially pertinent in the midst of social and communal problems that confront us in these later times.

Since the Bible was essentially a way of living for the ancient Hebrew, the philosophic writing of Maimonides in his *"Guide for the Perplexed"* was never removed from the realities of human experience, although its perspective and grasp reached out into the loftiest heights of the cosmic process.

TRAUMATIC SURGERY OF THE CHEST

By Stuart Zeh Hawkes, M.D., Newark, N. J.

Rewritten from a paper presented at the Graduate Surgery Seminar, New York University College of Medicine, November, 1934. Read before the Monday Night Club, Newark, N. J., May, 1935

This paper is prompted by the ever-increasing number of chest wounds caused by automobiles and other influences found in the large urban areas of this country. A few years ago, this type of injury was not common and did not come under the care and treatment of the majority of surgeons, but today, the treatment of chest injuries must necessarily be part of his armamentarium. The philosophy of intelligent treatment can only be based on a fundamental knowledge of the normal anatomy and workings of the chest. It might, therefore, be well to review some of the major outstanding principles involved. Even this study is difficult and dangerous if conclusions are to be reached which will serve as a yardstick for the general surgeon, for the reason that the modern concept of traumatic chest surgery, based on anatomy and physiology, is quite new and as yet not backed by a sufficient period of years of trial and error. Many men of eminent authority, in their writings, draw exactly opposite conclusions while writing on the same subject. Whatever may be the final decision on some of these points, we may still limit the discussion to some definitely founded anatomical and physiological principles, which if practically employed, will lead to a more rational treatment of many traumatic chest conditions.

ANATOMY

Thoracic Cavity is a term used to denote a visceral compartment enclosed by the walls of the thorax and occupied by the thoracic viscera. On either side we have the lung surrounded by the pleura with its cavity, and, in the middle, the thymus gland or its remains, the pericardium and heart, great vessels, nerves, trachea, thoracic duct, and oesophagus, all closely associated and surrounded by connective tissue, forming a dividing wall, and grouped together under the term mediastinal septum, standing between the right and left sides of the thoracic space. The limits of the thoracic space are given laterally by the skeletal parts of the thorax. The arched muscular motile diaphragm forms the inferior limit, while the barrier presented by the scalene muscles and cervical fascia forms the resilient superior boundary which, it is to be observed, lies above the plane of the superior aperture of the thorax and therefore in the base of the neck. These boundaries are approached by the extension of the parietal pleura, which is reflected from the lung and is continuous with the pulmonary or visceral pleura. It is connected with the thoracic walls by loose connective tissue, the endothoracic fascia. The right and left pleural sacs are thus normally potential spaces only, separated one from another by a saggital partition, the mediastinal septum. There is a small amount of serous fluid normally in the pleural cavity for lubrication of the opposed surfaces of the pulmonary and parietal pleurae.

PHYSIOLOGY

An important physiological consideration is the question of what happens to an indivdual when an opening is made into his chest and what effect it has upon the intrathoracic function. The exact nature of the disturbance is today probably one of the most fundamental questions in the whole field of thoracic surgery because the effect of an open pneumothorax concerns not only the aeration of the lungs but also the circulation of the blood in both the pulmonary and systemic circuit. One of the chief obstacles to the early development of chest surgery was the fear of creating an open pneumothorax and in order to gain a clear concept of the nature of the disturbance produced by a change of intrathoracic tension, it is necessary that one should first familiarize himself with the main features of normal respiration.

In the normal condition there is no actual pleural space. Because of their elasticity, the lungs are constantly tending to collapse, but

at the same time there is a stronger adhesive force between the visceral and parietal pleurae which keeps the lungs in contact with the chest wall. The result of these two opposing forces is a negative sucking pressure in the pleural cavity. When the tendency to separate the pleurae becomes greater, as during inspiration, the negative sucking pressure becomes greater. This pressure is found to be greatest at the end of inspiration and conversely, the nearest to positive pressure at the end of expiration. In the normal subject, however, the intrapleural pressure readings do not usually exceed the atmospheric pressure even at the end of expiration, except in the trachea where the pressure is positive.

The act of inspiration is a very complicated process if the complete act is unraveled in detail, but the principles involved are very simple: The thorax is enlarged, the intrapleural sucking pressure is increased, and air rushes down the trachea to fill the lungs. The diaphragm is the chief muscle involved in the enlargement of the thorax from above downward, accounting for 25 per cent of the total air admitted to the lung. With each descent of the diaphragm, the abdominal wall is protruded because of the displacement of the abdominal viscera. The thorax is simultaneously enlarged transversely by elevation of the ribs. The chief muscles concerned are the external intercostals and the serratus posterior superior. Accessory muscles which may be brought into play include the scaleni, sternocleidomastoid, trapezius, the pectorals, rhomboids, and serratus anterior. Expiration, on the other hand, is chiefly a passive phenomenon. When the muscles of inspiration cease to contract and elevate the ribs, the thorax by its weight, diminishes in size, the diaphragm rises and the elastic tissue of the lungs is enabled to force air out of the lungs.

With the lungs once inflated at birth, it is impossible to rid them of air completely thereafter despite a maximum expiratory effort. The remaining air after any forced expiration is called the residual air. It amounts to about 1500 c.c. in the average adult. The air taken into the lungs during ordinary respiration is called the tidal air, amounting to about 500 c.c., while the air in motion during a maximum inspiration or maximum expiration after ordinary breathing is the complementary and supplementary air respectively. The sum of these three is known as the vital capacity, averaging about 4000 c.c. of air normally.

PNEUMOTHORAX

The danger of an open pneumothorax was known to the ancient Greeks. Celsus, in discussing dissection on living criminals, states, "It is indeed true that the abdomen, with which our argument is less concerned, can be opened while a man yet lives, but as soon as the knife reaches the thorax and cuts the transverse septum, which is a membrane dividing the superior parts from the inferior and called the diaphragma, the man at once gives up the ghost, and thus it is the breast and its viscera of a dead and not a living man which the murderous physician examines." [1]

Until very recent times an accidental admission of air into the pleural cavity through a free opening was generally regarded with great dread because of the possibility of immediate death. Later, an opening, no matter what the size, was thought to collapse immediately the lung on the opened side, the mediastinum acting as a partition to protect the other lung. There was but little realization of the extent to which the lung of the unopened pleura was handicapped, because of mediastinal displacement. At the present time the controversy centers around just how much the opposite lung is affected when an opening is made in one pleural cavity, and just how large this opening may be with safety. In 1918, Graham and Bell, working with the United States Army Empyema Commission after experimental study, came to several momentous conclusions which bear quoting as today they are accepted as current thought:

"1. Older conceptions are erroneous which imply that in pneumothorax only one lung is affected and that that lung is rendered functionless, regardless of the size of the opening.

"2. On the contrary, both lungs are affected; and, when a small pneumothorax is present, they are both affected to nearly the

extent. The larger the opening or the higher the pressure, the more difference between the opened and unopened sides. Moreover, a lung does not become functionless merely because there is a free communication between the pleural cavity of that side and the outside air. If such were the case, then a bilateral open pneumothorax would promptly result in death from asphyxis. As a matter of fact, a bilateral open pneumothorax in an experimental animal is well tolerated and is compatible with life for an indefinite period, provided that the bilateral openings are not too large.

"3. A unilateral open pneumothorax will result in death if the opening is made sufficiently large.

"4. The really important matter is the amount of air which enters through the opening at each inspiration and the ability of the individual to compensate for the encroachment on his respiratory surface which is caused by the pneumothorax. Roughly speaking, this relationship becomes a question of the relation of the size of the opening and the value of the vital capacity of the individual. When the vital capacity is high, a larger opening can be tolerated than when it is low; and no opening at all of any appreciable size can be withstood if the vital capacity is so low that it practically equals the tidal air. In other words, even a very small opening will result in fatal asphyxia, if, before the opening is made, the vital capacity is so low that in spite of maximal inspiratory efforts only enough air is inhaled to satisfy the tidal air requirements." (This statement does away with the number of square cm. of chest that can be opened except when computed against the individual's vital capacity.)

"5. Obviously, the conclusions mentioned above are concerned only with relationships as they exist in a normal thorax, that is, one without adhesions or inflammatory induration. If sufficient adhesions exist or if the mediastinal pleura has become rigid by inflammatory induration, the relationships already discussed no longer hold true, and no ill effects from pressure disturbances will result, even if a very large opening is made."

The usual attempt to compensate for the increase in pleural pressure is to take a deeper inspiration. Theoretically, all that is necessary to prevent a fatal asphyxis is to inspire enough air to satisfy tidal requirements. It is really of little importance to know exactly in any given case how large an opening can be tolerated. The important thing to realize is that those whose vital capacity is low for any reason may die as a result of even a small opening, or a small rise of pressure, unless measures are taken to prevent serious consequences.

There are other effects which should be mentioned as occurring on puncturing the chest. There is a stasis produced in the general venous system. There is a diminished pulmonary circulation of blood due to pressure with resulting partial asphyxia. The chance of infection of the wound in an open pneumothorax is very great and is much greater than in the case of an open wound of the abdomen. Two reasons are given. The first is that with the suction of air through the pleural opening, large numbers of bacteria are drawn in, and the other is that the lung retracted away from the chest wall by the pressure change is unable to seal the opening as is the case in the abdomen by the action of the omentum and viscera.

THORACIC WOUNDS

Having reviewed the normal functioning of the chest, and some of the results of abnormal pressure changes, it may be well to discuss the usual agents which cause intrathoracic injury separately and then study them from the viewpoint of effect and treatment. Probably the most common chest injury is a fracture of one or more ribs. The fractured ribs may have no influence on intrathoracic functioning or they may produce marked changes. In the first place, the rib may puncture the pleura, producing a pressure change, or it may produce laceration and hemorrhage of the lung or of an intercostal artery with resulting hemorrhage into the pleural cavity. The rib may also pierce the intraperidcardial structures. The broken rib then may account for almost any type of injury and probably accounts for a large percentage of the injuries we see. The

puncture wounds or laceration resulting from stabbings differ somewhat from injuries caused by ribs. With this type of injury there is usually a direct communication with the outside environment, while complications caused by fractured ribs usually occur without any such communication. This injury may again produce hemorrhage, lacerated lung, pneumothorax or cardiac damage. The puncture wound may seem trivial, and unless care is taken, it may seem so slight as to escape the necessary attention it deserves. The third type of injury is one of massive compression of the chest. It comprises a small group which usually causes almost immediate death, and in which the intrathoracic structures are so distorted as to be incompatible with life. It is important to get a careful history of the injury first and the type of accident in order to determine compressive injuries as compression may occur without leaving any cutaneous evidence of traumatic violence. In a recent study made in Dr. Martland's laboratory covering a ten-year period, the most marked injuries of thoracic viscera were found unaccompanied by external marks of violence. Some of these patients might have lived if the serious nature of their injury had been evaluated.[2] Having determined the three main ways in which chest injuries occur, namely, from fractured ribs, puncture wounds and by compression, we may now proceed to study the effects on the individual and the methods of treatment.

SUBCUTANEOUS EMPHYSEMA

One of the common results of fractured ribs is subcutaneous emphysema. This condition is caused by a tension or positive pressure pneumothorax which is produced by a laceration of the lung, allowing air to escape into the pleural cavity with the pumping mechanism of each breath, adding to the pressure. Air is forced into the pleural cavity and the pressure keeps increasing. The air naturally seeps into the deep tissues, through the lacerated pleura, producing swelling and the crackling feeling so well known. It may remain localized to a small area or may extend over the body to involve it almost entirely. Dr. Atkinson of the Newark City Hospital in a recent article in the American Journal of Surgery, cites a case which blew up like a balloon.[3] The patient was inflated almost from the top of his head to the tip of his toes. The condition is not dangerous except that it produces respiratory embarrassment due to the increased load on the chest and the increase of pressure within. Many methods of treatment have been suggested, such as strapping the chest, multiple incisions over the chest to allow the escape of air, but such treatment alone does not get at the root of the disorder. If we remember that we have a tension pneumothorax with increasing intrathoracic pressure causing respiratory embarrassment and cyanosis, we will see that a needle introduced into the chest and attached to a pneumathorax outfit, so as to withdraw air from the chest, will reduce the pressure, check the egress of air into the subcutaneous tissues and the patient will usually be quickly relieved if this is the only abnormality. A stab wound lacerating the lung with the wound of entrance which does not correspond to the pleural wound will produce the same result, as the air will leave the pleural cavity but not be able to reach the skin surface. This usually occurs when the individual is stabbed with his arm raised in attack or defense. When the arm is lowered, the skin laceration falls below the level of the pleural opening. It may also be produced by a slanting blow where the implement glances off a rib then penerates the interspace above or below the rib. Bleeding into the chest may occur at the same time, and if massive, it will be discovered when the needle is introduced into the chest. The treatment is thus simplified to the introduction of a needle taking an intrapleural reading and, if positive, withdrawing air. If the condition is marked, the needle may be left in place, allowing a tube placed under water to blow off air with each respiratory motion. If a tube is not necessary, daily intrapleural readings are taken to determine any increased pressure, and if necessary, air is withdrawn.

MEDIASTINAL EMPHYSEMA

Another type of emphysema, but with a different causative agent, is *mediastinal* emphy-

sema. In the older writings it was known as *compression cyanosis*. The patient presents a livid purplish appearance of the face, neck and shoulders with small petechial hemorrhages beneath the skin. He is acutely ill, has dyspnea, a rapid pulse, and congestion of the superficial veins in the neck. The mechanism is some compressive force. Air reaches the mediastinum through a break in the trachea or larger bronchi or esophagus, producing increased mediastinum pressure with resulting stasis in the large thin-walled veins. The petechia are caused by the initial compressive force raising the pressure in the terminal vessels and thus producing small hemorrhages. These are never fatal. The dangerous part is the following increase in mediastinal pressure and respiratory embarrassment which causes a slowing up of the systemic circulation. The treatment is an immediate opening of the mediastinum through an incision in the suprastemal notch which allows the air to escape. Tracheotomy is often advisable and necessary.

BLEEDING

Should bleeding occur in the chest due to the negative pressure, it may continue for a long time from even a small vessel. This bleeding may be from either a damaged intercostal or a laceration of the lung. If the bleeding continues, the intercostal vessel can be ligated. A lung laceration will often ooze for a long period. It can be readily sutured by opening a small hole in the chest wall and closing the hole in the lung. This measure will also very often close the source of air causing a tension pneumothorax. The procedure in either case is not indicated unless the bleeding has continued in spite of all effort at controlling it. We should not forget that the pleural cavity will hold two or three litres of blood, and that a patient may bleed to death quickly within his own chest. Foster, in an excellent article,[4] recently stated that 95 per cent of these cases are still treated expectantly in spite of World War experiences. He advocated removing the blood where any sizeable hemorrhage occurs and replacing it by a measured quantity of air, the amount being about 200 c.c. in excess of the blood removed. The positive pressure serves to check bleeding. The removal of the blood eliminates two possible bad results. In the first place, blood is an ideal culture medium for bacterial growth, and, secondly, blood takes a long time to reabsorb. Failure of complete absorption may lead to permanently thickened pleura and deforming intrapleural adhesions. This procedure naturally need not be done in cases of slight bleeding.

There are certain other cases which demand immediate operative interference. They fall into several classes. Large sucking wounds of the chest should be closed as soon as possible. In our past discussion of the physiology, we have seen that such wounds by their very size may be so large as to embarrass the patient's respiration by cutting down the intake of air below the vital capacity. There is also the danger of infection to be considered. These wounds should be debrided and closed tight. If the defect is too large to allow immediate closure, tampon dressings should be placed over the wound until the patient's condition warrants further operation and until a positive pressure anaesthetic apparatus is available. This machine may be of the simplest type and need not be the complex machines which were used in the past. Any closed method anaesthetic machine will serve the purpose.

STAB WOUNDS

Stab wounds of the chest are another group which often need immediate operative interference. There are three major danger zones, and if the stab wound occurs in one of these regions, clinical experience has shown that it is far safer to operate immediately. These zones are: (1) Around the base of the neck and first rib. (2) Along the borders of the sternum. (3) Over the left lower chest and precordium. In the first two zones, severe massive hemorrhage may occur which cannot be controlled by producing positive pressure in the pleural cavity. They usually sever some large vessel which will exsanguinate the patient quickly unless immediate steps are taken.

HEART WOUNDS

Over the precordium and lower left chest, a wound of the heart is to be suspected. These heart wounds can be sutured successfully if the patient is brought to the operating room in time. Several weeks ago, at the Harlem Hospital, two cases of successful heart suture were presented. Both these patients were colored men who had been stabbed directly through the left ventricle. After being stabbed, they had run a considerable distance until the pericardium had filled with blood and they had dropped to the street in collapse. On arrival at the hospital, they were in extremis. They had been taken to the operating room immediately and an infusion started. At the time of operation they were both pulseless, without any blood pressure, breathing slowly, and in general, might have been considered hopeless. By a quick hockey-stick incision, the tissues were laid back and the ribs resected over the precordium. The precordium was filled with blood and the heart had apparently stopped beating. The pericordium was open, the heart grasped in the hand, at the same time placing a finger over the stab into the ventricle. While the bleeding was thus controlled, several chromic sutures were placed in the heart muscle. In both these cases, when the tamponade of the heart was released by opening the pericardium, the heart began to beat again. The operation was completed by sewing the pericardium to the chest wall, thus leaving it open for drainage. An electrocardiogram taken post-operatively in both these cases showed what would have been interpreted as coronary disease with occlusion. Successive electrocardiograms gradually showed a return to normal as the myocardium returned to normal. These are cited not only because of their interest, but to show that heart injuries may be revived by immediate surgery. Stab wounds occurring in the left lower chest may also perforate the diaphragm, causing injury to the spleen or stomach and necessitating immediate abdominal surgery. Stab wounds of the right side are less dangerous because liver damage will usually control itself.

Any severe chest wound may give referred signs and symptoms to the abdomen. Two cases have recently been seen which were in shock due to chest injuries and in which there were apparent signs of possible associated intra-abdominal injuries. They presented abdominal rigidity and tenderness to such a degree that abdominal operative interference was considered hourly. With treatment of the shock and the existing known chest conditions, the abdominal signs disappeared.

In closing, I should like to urge that the pneumothorax machine be used more in a diagnostic and therapeutic rôle than is usually customary; and when a doubt in possible diagnosis arises, the introduction of a needle will cause no harm to the patient and often supply the diagnosis and point out further steps to be taken.

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DISCUSSION

Dr. Richard H. Dieffenbach: I wish first to compliment Dr. Hawkes on his excellent presentation and the thoroughness with which he covered so extensive a subject. I am very glad that he stressed the possibility and frequency of severe lung and intrathoracic injuries without external evidence of violence. This is a very important point and one with which the medical profession and even many experienced surgeons seem to be unfamiliar.

He also mentioned the slow, continued bleeding that may occur in lacerated lungs due to the negative intrapleural pressure. These, I believe, are frequently overlooked, especially as the symptom of pain is often absent for several days, and does not manifest itself until the extravasated blood seems to act as an irritant to the pleura.

Suturing the heart is a problem with which anyone may be confronted, and a few points in technic may not be amiss. Give yourself ample exposure and do not worry about sacrificing a little more or less of the costal-cartilages or ribs. It is usually easier to hold the heart by passing a suture near the apex for steadying purpose. Use atraumatic needles—such as are employed in intestinal work—because if a heavy needle and suture are dragged through the heart muscle the resulting hemorrhage may be difficult to control. Leave the pericardium open; suturing it may cause heart tamponade. Always drain the pericardium. Close the defect in the removed costo-cartilages by suturing the lung across.

Again I wish to thank Dr. Hawkes for the privilege of hearing and discussing so excellent a paper.

SOME OF THE NEW DEVELOPMENTS IN THYROID AND PARATHYROID DISEASES

By Frank H. Lahey, M.D., Boston, Mass.

Read before the Medical Society of Hudson County, N. J., February 5, 1935

I always enjoy coming here. I feel that since so many of the men with whom I have had dinner this evening are interested in our clinics, that I would be remiss if I did not tell you that you would all be welcome at any time to visit the clinic. I would be delighted to show you everything there is to be seen, particularly in the way of medical activities. Those of you who are interested in surgery could always find out in advance the operating lists in the various departments of the clinic. We are glad to have this opportunity to extend to you a hearty welcome.

I would like to present some of the newer things which we have learned in connection with thyroid surgery and I would like to present also some of the older things with which you are familiar, with which we have all had considerable experience and in connection with which I hope I can say something that will be of practical value to you. I think it is one's duty always, in discussing subjects, to present his experiences and it is with this purpose in mind and not with any conceit (because I must of necessity make some dogmatic statements regarding the various thyroid conditions) that I tell of my experiences.

Up to last week, we have operated upon 13,365 patients for goiter. We have had the opportunity to have experience and to make all the mistakes there are to be made. One point I wish to stress is that hyperthyroidism does not produce gastric hyperacidity, the average acid being plus 46. In 20 cases with a metabolism of over 35, there were 18 with a free acid present; under 35, and 5 cases with free acids of 4 and 18. It used to be said that hyperthyroidism tends to produce hyperacidity and duodenal ulcer. We have not seen this associated with hyperthyroidism and we do not believe that hyperthyroidism tends to produce free hydrochloric.

That hyperthyroidism tends to produce hypertension is also an erroneous impression. The tendency is upward with age but the relation between the systolic and diastolic is the same. The basal pulse and basal metabolism tend to be in proportion to blood pressure. We believe that hypertension is not particularly improved by the relief of hyperthyroidism.

Intrathoracic Goiter: Intrathoracic goiter should not exist. The mortality in operations for this type of goiter is relatively high and if they had been discovered early before they became intrathoracic, many would not be subjected to the removal. They should be removed before they have penetrated this deep.

In 1100 cases of intrathoracic goiter, we have never had to do a tracheotomy for a collapsed trachea. If you remove the pressure on the trachea, it will always expand. As soon as you remove the goiter it will spring open and will not require a tracheotomy. Search behind the trachea for conditions of adenomatous thyroid. If you find a lateral bulging of the trachea, search for thyroid tissue. All extremely serious intrathoracic goiters should be handled carefully as this type so presses on the trachea that the patient does not get air and the removal of that goiter is so shocking that it will kill most of the patents. We have learned how to handle this successfully. The first thing to do is to tie the superior thyroid artery which cuts down the blood supply. Then make an incision and remove the manubrium of the sternum. The patient can then breathe. The goiter may then be removed and he will not die. In these cases there is always pressure on both internal jugulars and the resulting dilated neck veins are the superficial attempts at compensation. From 1915 to 1925 we had a mortality of 2.4 per cent; from 1925 to 1930, .3 per cent, and from 1930 to 1933, 1.4 per cent. Surgery is always advisable before these goiters become intrathoracic.

Diabetes and Hyperthyroidism: The following is based on a review of 250 patients with diabetes and hyperthyroidism. The first

point is that hyperthyroidism adds definitely to the seriousness of diabetes. In a series up to 1928 the mortality was 2.7 per cent. In the last series it dropped to 0 by increasing the percentage of two stage operations. I wish to stress the fact that the assocation of diabetes and hyperthyroidism increases the seriousness of the disease and two and three stage operations are usually necessary.

Toxic Adenoma and Diabetes: This is the most serious of all thyroid states. The mortality was 7.7 per cent in an old series. The present mortality is 3.9 per cent.

Some of the important features concerning diabetes and hyperthyroidism: The disease is intensified with infection. It has a diminished carbohydrate tolerance and increased insulin demand. Hyperthyroidism has the same effect as infection. We have never seen a patient with diabetes cured as a result of being relieved of hyperthyroidism but they are much easier to manage when they have been relieved. What the diabetic needs is the most complete and immediate relief of the thing which intensifies his diabetes and that is hyperthyroidism. These patients should be admitted promptly to surgery. There is no alternative.

The patient who has no toxicity and no pressure receives the worst advice. The doctor tells her not to do anything about it. Ninety-six per cent of cases of cancer arise in this type of patient because it is impossible to tell when these growths are becoming malignant. In such cases we advise surgical removal at once. The properties of malignant tumors are their ability to penetrate the blood vessels, to be borne off with the blood stream and to metastasize.

Lateral Aberrant Thyroid: The main or principal origin of the thyroid is median. There are occasionally lateral origins for thyroid tissue. These bodies can be seen in segments of thyroid tissue in the form of small soft gland-like tumors, movable, non-painful. They have the unfortunate property of becoming malignant. We have had 23 of these, of which 3 have died. If you have glands running up and down either side of the neck, they should be removed and submitted to the pathologist. All patients with cancer of the thyroid should have a biopsy.

Exophthalmic Goiter: One sees vigorous exophthalmos in two forms: (1) That associated with hyperthyroidism, and (2) that associated with myxodema. The result is the same. The treatment is the same, but unless this disease is treated properly there will be loss of both eyes and resulting blindness. The conjunctiva has no blood vessels and is nourished by osmosis. It is therefore laid open to early erosion. There is increased bulging of the eyes, increased lid pressure interfering with the nourishment of the conjunctiva which is followed by erosion, laceration, edema, and finally sloughing. The first step in the treatment of this disease is to start to save these patients' eyes. When eye symptoms first appear, the thing to do is to sew the lids together. With the lids sewn together, you overcome the lid pressure and then you are at liberty to remove the exophthalmus. Make a lateral parietal incision, turn down the bone flaps and permit the ocular muscles to bulge up into the bony cavity. This is the salvation of those patients with intractable exophthalmus. Patients of this sort need only to get corneal ulcer to lose their eyes. If there is any trouble such as lid pressure, these should promptly be sutured together.

Mr. Perkins has discovered a method of accurately determining blood iodine. This blood iodine is definitely related to thyroid toxicity. The determinations were not accurate until Mr. Perkins developed a micro-determination of blood iodine. We can now read it in what we call micrograms. These are 1/1000th of a milligram. This iodine tolerance test corresponds to glucose tolerance in diabetics. The iodine is injected into the patient intravenously. In severe exophthalmus you have no iodine in the thyroid gland or very little. If you give that patient Lugol's solution you will produce involution or change in this condition. As you change the picture of the gland, that gland begins to accept and store iodine and the patient begins to improve clinically. Whether the improvement is by surgery, rest, or radium, if you improve him you produce involution and storing of iodine in the gland. (Specimens of

some thyroid tissue showing various amounts of iodine content during treatment shown.)

Blood Iodine Determinations: If a patient has a normal thyroid he has plenty of iodine; therefore his gland does not have an iodine thirst, but in exophthalmic goiter there is no iodine, with the result that the gland has a tremendous thirst. Mr. Perkins has developed a so-called iodine tolerance test. The patient is given 72 milligrams of iodine intravenously. You then establish his iodine tolerance curve. If he has plenty of iodine, that gland has no affinity for it and so it stays in his blood, which promptly rises above the normal. If you have a patient with a high basal metabolism, his gland has such a tremendous thirst that it takes it up promptly and his curve stays well below the normal. This test, however, has its drawback. For instance, if a patient has been receiving iodine over a period of time before this test is given, the result will not be accurate. If the patient is not rested, it is also apt to be confused. But here is a test which is uninfluenced by emotional upsets and should quite accurately indicate the presence of iodine in the thyroid gland.

What is hyperthyroidism? We call it intoxication. We do not know that hyperthyroidism is intoxication but we do know it is excessive combustion. In order to offset this, the patient must have fluid and fuel and if he does not take in fluid and fuel the hypercombustion goes on just the same and he begins to burn himself. I believe that the disastrous results of hyperthyroidism are not those of a poison but the results of excessive stimulation by combustion. Death is most probably a liver death, not a cerebral death or intoxication death. It is a lowering of liver tolerance. These patients are benefited by the factors which tend to increase liver tolerance, viz. glucose and fluid. These patients die with high, unexplained temperatures and often jaundice. At any rate, when you have patients of this type, these patients will die in spite of anything you do unless you do the right things very promptly. The first most important thing is something to offset the hypercombustion and the next is something to diminish the thyroid activity. A thyroid crisis is like a diabetic coma. The thing to do is to prevent the patient from going into a crisis. It is important to know the indications of an impending crisis. The first indication is: (1) Unexplained rises in pulse rate, (2) infection, (3) vomiting, and (4) diarrhea. These patients must have constant fuel and fluids, which are best given to them intravenously, if you are to pull them through the crisis. We also advise operation on patients close to a crisis. In these patients with vomiting and diarrhea, it is difficult to get iodine into them. However, it can be given intravenously. This checks the activity of the thyroid. We then do a partial thyroidectomy to prevent them from going back into the crisis, and later, a complete thyroidectomy. If you have a patient who is severely toxic, give him constant intravenous injections of salt solution, glucose and iodine for three or four days before operation.

Total Thyroidectomy: I do not believe it is going to work out well with cardiac decompensation but will work out satisfactorily with some cases of angina pectoris. The theory is that you create an artificial reserve. The metabolism is diminished, the load on the heart is decreased but this creates myxodema and the result is that the heart is not as efficient. These patients who have cardiac decompensation with hyperthyroidism have no cardiac reserve to speak of and it is difficult to get them at a sufficient metabolic level. Angina patients do well with total thyroidectomy because you can produce any degree of minus metabolism and give the patient relief, who is willing to put up with anything rather than suffer the pain. Therefore, in the long run total thyroidectomy will not prove to be of great value in decompensation but will prove of value in the anginas.

Thyrocardiac Statistics: I wish to attract attention to a group which tends to be overlooked. This is a different but more satisfactory situation than occurs in patients with cardiac decompensation submitted to total thyroidectomy. This group have real cardiac decompensation but have something that will give good results. They have tremendous cardiac reserve as indicated by the end results of 208 cases. In this number only three are decompensated; 205 have had their compensation re-

stored and have retained this compensation from two to ten years. Why? This is the point: If you have a patient who has no cardiac reserve and he gets a hyperthyroidism, you never see him because it kills him. If he can live long enough with hyperthyroidism and decompensation, he has a tremendous cardiac reserve and if the hyperthyroidism is relieved, he can regain his decompensation.

Blood Cholesterol in Hypothyroidism and Hyperthyroidism: A particular note of interest is the effect on blood cholesterol of hypothyroidism and hyperthyroidism. The effect of hyperthyroidism is to diminish the blood cholesterol. The trouble with this is that we have no accurate normal. On the other hand, with patients with myxodema or partial myxodema, then blood cholesterol is of great value. There are a large group of cases which have minus metabolisms and do not have myxodema. Blood cholesterol in severe hyperthyroidism is lowered. The patients with true myxodema have a blood cholesterol which is 112 or 114 above normal. Blood cholesterol is a better indication of myxodema than is basal metabolism and as the patients improve with thyroid extract, the blood cholesterol will go down to normal. It is the best method of separating patients with minus metabolisms who will be benefited by thyroid extract from those who will not and who do not have myxodema.

Hyperparathyroidism: Adenomas of parathyroid can go unrecognized. We know that this has existed for years and we have not discovered it. You should suspect that a patient has an adenoma under these conditions: When he complains of joint pains, particularly back pains; when the patient has a particularly rounded and stooped back who has previously been straight; when he has lost stature, when he has kidney stones—that patient has a probable or possible case of hyperparathyroidism. You should do their blood calcium and blood phosphate. We have seen one patient who has had fourteen spontaneous fractures. Removal of this adenoma permits the bones to recalcify, the patients lose their pains and are restored to normal. These growths have been found in the vessels of the superior thyroid, outside of the parathyroid, along the lobes of the isthmus, on the front of the gland, in the gland, along the side of the gland, in the inferior parathyroids, below the isthmus, at the terminal end of the lower branch of the inferior thyroid, behind the inferior thyroid and at the terminal branch of the anterior thyroid. In every patient with kidney stones, you should do a blood calcium because a good many of them will prove to have stones due to hyperparathyroidism. This will produce three types of kidney stones: the typical, the small ones in the tubules, and the deposit of calcium phosphate in the kidney itself.

COLITIS FROM THE PRACTITIONER'S STANDPOINT

By Anthony Bassler, M.D., New York, N. Y.

Read before the Mercer County Medical Society

Diagnoses like "unstable", "spastic", "dysfunction of the colon" are due to lack of knowledge of pathology. While the reconstructive power of the colon is great, any one of a number of factors continually irritating the colon causes a reactionary pathology which can be demonstrated in pin-point ulcerations and erosions, cytological changes in any of the cells of the walls, cell infiltrations, lyses of the follicular glands, hypertrophy of the lymph follicles, pigmentation of the mucosa, deposits of fibrous tissue mostly around the arterioles, obliteration of veins, dilatation of arteries, denudation of capillaries, thickening of the serosa, etc. While these pathologies are due to some irritative factor they may come on from bands, kinks, angulations, etc. The factors that are important are the intestinal toxemias represented in the indolic, saccharo butyric and mixed forms, various specific infections represented in chronic carriers of B. dysentariae, metadysenteriae, paradysenteriae, coli, typhosis,

streptococci, staphylococci and anerobes; neurological, especially in the non-adjusted types of individuals; parasitic in which the chronic carriers of ameba Trichomonas, Giardia and round worms are the most important; allergic factors, and finally, the factors found in ulcerative colitis, bacterial, deficiency and hereditary.

While accessory factors such as chronic appendicitis, gall-bladder and pelvic diseases with rectal states and the types of secondary colitis which terminates lethal diseases are important, these factors are not as frequent as those aforementioned. In the more common forms of chronic colitis all the pathologies represented in any book on cellular pathology may be found and these conditions may exist without much, if any, local or general symptoms. Often a habitual constipation case presents extensive pathology in the colon not suspected or perhaps ever known. It has been suggested that the diagnosis of colitis is reserved for the ulcerative form and all the other types are functional. In my opinion this is an error due to limitation of knowledge of pathology and lack of proper examinations.

Generally throughout chronic colitis local symptoms in the abdomen, mainly those of distress and pain, the long continued history, the careful x-ray examination not only for spasms and atonies but mainly in rugal studies and the laboratory are essential for diagnosis. In the toxic form of colitis the original classifications and examinations of stools suffice. The indolic form requires high vegetable and farm diets, use of small doses of calomel, beta naphthol benzoate, bismuth salicylate and perhaps salol. Constipation additions to the diet are usually required but medicinal measures to move the bowels usually increase the pathology. In the saccharo butyric type, high protein diets are required in which alkalies and rectal instillations of oxygen are worthwhile. Infective colitis due to specific types of organisms calls for technical examinations of stools and the use of various vaccines and antigens, and usually more or less of a bland type of diet and the additions of vitamins, mainly B2 G and D. Dry colitis is largely a stercoral affair due to saprophytes which thin out the mucosa. In this form the cure is dependent upon the results accomplished by anti-constipation diets, and these cases are the most prompt in cure. In the mucous forms, the sympathetic nervous system together with endocrine significances are important. These patients as a rule are out of kilter in hereditary or constitutional ways. They often require rest treatments, various types of diets, and social and domestic control together with endocrines, different kinds of tonics and perhaps modest doses of senna or cascara.

There is a close association between the brain and the colon and this explains neurological colitis. Largely these are individuals of neurological types in which environmental, economic, religious, domestic and financial problems figure as causes. The trend of life today is much too fast for these people and the profession is not devoting enough interest and time to the handling of them. The patient may go too fast but the physicians should not be too busy, too little interested, too prejudiced and not broadmineded enough to understand the factor in back of this form. It is in this type that mental and social hygienic methods figure prominently to which may be added sex problems and others. Common sense, reasonable advice, the philosophy of daily life and lessons from the Bible often serve to good purpose. It may be necessary, however, to use rest cures, sanitariums, trips away from home, etc., before sufficient benefit is brought about. These cases require tonics, the use of various local treatments in which hydrastis and ichthyol are beneficial.

While a good many men in medicine believe that parasites in the intestinal canal can do no harm, they do bring on pathologies of chronic types and often render the individual susceptible to other infections. The chronic ameba carrier must be diagnosed and treated in the specific ways. Instances of trichomonas and giardia require transduodenal lavages with hypertonic solutions. The round worms can be handled in the well-known ways.

Allergic colitis, which is mostly a hereditary affair, is controlled in 80 per cent of the instances, so far as foods are concerned, by the elimination of milk, wheat and eggs. The

skin testings are only of value in half of the instances and the sensitization methods are of no interest to the essayist. There are no allergies in bacteral infections. Here we deal with toxic effects and immunities, but true allergies never.

In ulcerative colitis, the B. dysenteriae is found in about 17 per cent of the instances, this with the various modified types in about 40 per cent but the streptococci are found in 100 per cent of all. Deficiency conditions are probably of more secondary significance than primary and are not successfully handled unless the ulcerative process is controlled. The treatment here is the use of any diet that would be ample and some are best treated by bland forms and others by roughage diets. Every case of ulcerative colitis has a chronic stasis and not a few cures are brought about by anti-constipation methods. The use of dyes has been given up and free oxygen as Felsen advises is not only a nuisance but has very limited value. Alternate injections of 200 to 500 c.c. blood infusions and half the ordinary size dose of mercurochrome given weekly has served to good purpose. "Albicol" powder, a combination of kaolin with additions (Drug Products Co., Long Island City), serves to allay the irritation. Various types of vaccines have been used, those suggested by careful stool examinations being the most worthwhile. In this the vaccine of the gram positive diplococcus (erroneously called the Bargen bacillus) has served to good purpose in perhaps 5 per cent of the cases. The best results have been brought about by multiple types of vaccines in which the streptococcus present figures predominately. When surgery is performed it should be done on a step-up plan and always conservative. Beginning with the procedure of cecostomy, irrigations and various types of solutions should be engaged in. If the clinical course of the findings by proctoscope do not show distinct benefits, an ileostomy may be in order, this finally to be finished off with an ileac implantation. It must, however, be remembered that this is a disease of the young person and that tincture of time and essence of patience clears up the vast majority of them. When in a late case polyposis exists, colectomy is required.

Dr. Bassler finished with a plea for the more general use of the term "chronic colitis" rather than the erroneous entities that are today employed, the more deep study of the cases and the use of the term "chronic colitis" in place of the ones used generally today. With this laboratory studies, careful x-ray work and the use of the proctoscope are essential for the handling of a disease that is common in the practice of everyone irrespective of whatever department of medicine he may be engaged in.

SKIN GRAFTING

By Lyndon A. Peer, M.D., Newark, N. J.

From the Plastic Surgery Department, Newark Eye and Ear Infirmary, Newark, N. J. Read before the William Pierson Medical Society, Orange, N. J., February 19, 1935

Skin grafting is not a new branch of the healing art, and in tracing its early development we must go back to Indian medicine during the life of Buddah. As the Hebrews attained the highest eminence among Oriental peoples in hygiene, so the ancient Hindus excelled all other races of their time in operative surgery. Susruta, who lived about 450 B. C., left a written record, named after him, "The Susruta", which is the great storehouse of Aryan Surgery. In the Susruta is a clear description of a skin flap swung down from the forehead to replace an amputated nose. This operation was in great demand because of the Hindu custom of cutting off the noses from criminals, captured war prisoners, and philandering young men and women. The method was not know in Europe, however, until 1794, although it was used frequently in India up until that time.

Celsus and Galen, during the Roman period, described plastic skin flaps, taken from the

adjacent skin, for repair of the eyelids, nose, lips and ears; and through their records we know that the Romans understood many of the skin flap procedures in use today.

In 1597, Tagliacozzi, an Italian, described an operation for building a nose from a pedicle skin flap formed on the arm. Tagliacozzi was roundly abused by the church for meddling with the handiwork of God. In the nineteenth century, the most important advance, from the standpoint of plastic surgery, was the discovery and use of free skin grafting. Reverdin, in 1869, reported the growth of small shavings of skin taken from a sound portion of the body surface and placed on open wounds to hasten healing. Ollier, in 1872, and Thiersch, in 1886, used much larger skin shavings to cover raw areas. In 1875, Wolf, of Glasgow, successfully grafted a full thickness section from the arm to the upper eyelid. Many names have been omitted in this brief historical review, but the basic principles of our modern skin grafting are directly dependent upon these particular earlier discoveries.

TYPES OF SKIN GRAFTS AND INDICATIONS FOR THEIR USE

There are two main types of skin grafts, *pedicle* grafts, and *free* grafts. A pedicle graft or flap consists of skin and subcutaneous fat, which is raised from its bed, but is left attached to the surrounding skin by a pedicle through which it receives its blood supply. Pedicle flaps are best used in large tissue losses, such as reconstructing a nose or ear, or filling in defects about the face resulting from cancer excision. They are also indicated wherever there is distortion from deep scar formation.

The most important thing to remember when using a pedicle flap is to do the operation in stages rather than in one procedure. Time is of no consequence providing the final result is satisfactory.

Free skin grafts are of two main types:

1. Sections of skin consisting of epidermis and only a portion of dermis.

2. Sections of skin consisting of the epidermis and the complete thickness of dermis.

Pinch grafts, Thiersch grafts and split grafts[1] all contain only a portion of the dermis. Wolfe grafts include the entire thickness of dermis. The Thiersch graft is used where a thin covering is desired which is almost sure to take. Because it tends to assume a prune juice color, it is often used to replace superficial skin loss in burned areas, the graft blending well with the surrounding discolored skin. It is not suitable where deep scars have been removed, because scar tissue will again form beneath the graft.

Split skin grafts, which are thick Thiersch grafts, include a larger portion of dermis with the epidermis. They possess the advantage of retaining their color, and take almost as well as Thiersch grafts.

Wolfe, or full thickness grafts, include the epidermis and dermis, but not the subcutaneous fat. These grafts do not take as often as the Thiersch and split grafts, but form a thicker covering which seldom changes its color.

The most successful application of the Wolfe graft is in eyelid repair, where skin from one upper eyelid is used to replace tissue loss elsewhere in the eyelids. All types of grafts will take on fresh operative wounds, or on healthy, granulating surfaces. The Thiersch graft will take over bone or periosteum.

PREPARATION OF THE BASE FOR GRAFTING

All fresh operative surfaces may be grafted immediately following the removal of scar tissue or the raw area may be treated with wet dressings until granulations have formed and then covered by a skin graft.

Old surfaces may have exuberant granulations or there may be a deficiency of granulation tissue. Boggy and exuberant granulations are excised and silver nitrate applied. A 60 per cent alcohol dressing is then used and in a short time the area is ready for grafting. Sluggish granulations are treated by Dakin's solution or Balsam of Peru.

According to Davis,[2] skin grafts seldom take if the secretion of the granulating surface is acid. Therefore, one should test the secretion with litmus paper, and if the reaction is acid, apply one per cent sodium bicarbonate solution for a few days.

THE DRESSING OF GRAFTS

Much has been written concerning the proper amount of pressure to apply over a free

graft, and almost every surgeon has his own particular type of dressing, which, in his opinion, is necessary for a successful take.

My belief is that the amount of pressure should vary with the character of the base on which the graft rests, and with the success that the operator has had in checking bleeding. Excessive pressure applied on a graft over a bony surface, such as the skull, or tibia, will result in nutritional death of the graft and underlying tissues. Insufficient pressure over a graft which is placed on a bleeding surface will, likewise, result in nutritional death of the portions of the graft which are separated from the base by blood clot. Mutilation of the graft by numerous punctures is not necessary if bleeding is controlled, and a moderate, even pressure applied. I have had successful takes on the eyelid and elsewhere, when the graft was placed on a raw, non-bleeding surface and no pressure at all applied.

The essential things, then, are a clean, non-bleeding surface and moderate pressure to hold the graft evenly in apposition with its base. For this purpose, a thin pad of wet cotton with the under surface greased with vaseline is placed on the graft. This is covered by a flat sheet of rubber sponge a little larger in diameter than the graft and held firmly in place with adhesive. A gauze bandage is then used to obtain firm, even pressure over the rubber sponge, which, in turn, because of its elasticity, exerts even pressure over the graft.

Neither a necrosis nor a separation of the graft is apt to occur with this type of dressing. Dressings applied over free grafts are left in place for five days. The cotton is then gently removed, after a liberal soaking in hydrogen peroxide, and the graft inspected. A pinkish, red color indicates a take, and an opaque white color, a failure. The stitches are now removed and any dead portions of the graft are cut away, as these areas tend to become infected and envolve the adjacent, living portion of the graft. Vaseline is applied for three weeks, and then the patient is instructed to massage the area with cocoa butter three times a day.

Pedicle flaps are treated in the same manner as any surgical incision, excepting that the detached portion is inspected on the day following operation. Necrotic skin at the end of the flap is excised when a definite line of demarcation has formed between it and healthy portions of the flap. The pedicle is severed seven to ten days following attachment of the free end. When the detached end of a pedicle flap becomes blue, it indicates a poor venous circulation, and unless the excess venous blood is drained away the blue portion of the flap will die. Multiple incisions in the congested area and the application of live leeches are helpful in removing the excess of blood until normal circulation is established. It is wiser, however, to obviate such measures by taking more time in forming and delaying the flap. This insures an adequate balance between arterial supply and venous drainage through the pedicle.

Pinch grafts often give good functional results but are not desirable on exposed surfaces because of their poor appearance. A large split or Thiersch graft can often be used with better success whenever a pinch graft is indicated.

THE NOURISHMENT OF FREE SKIN GRAFTS

The dermal layer of the skin is normally supplied by branches from blood vessels in the subcutaneous fat. The epidermis has no blood supply and is nourished by serum which exudes from capillaries in the dermis. Split grafts and Wolfe grafts include the dermis, which is normally supplied by blood vessels. When placed on an open wound they are first nourished by serum from the raw surface on which they rest.[3] This serum penetrates the old blood vessels and connective tissue of the graft. After about twenty-two hours the earliest blood circulation occurs through an anastomosis of capillaries of about the same caliber. Later, there is an upward growth of capillaries from the surface inside of old vessels in the graft, and, finally, there occurs an invasion of capillaries from the host tissue into the tissue of the graft. This later, penetrating, capillary growth gives rise to a permanent circulation.

During the period of development of a blood supply in the graft, degenerative changes take place. These degenerative changes continue until the eighth day, when a balance is reached

and proliferation of the surviving elements occurs.

The same process takes place with Thiersch grafts, but the circulation is established earlier and degenerative changes are less marked.

Pedicle flaps are supplied by blood vessels running through the pedicle until a new blood supply develops from vessels on the grafted surface.

COMMENT

I have presented the subject of skin grafting in a positive manner in order to emphasize the rules favoring successful results. One must not suppose, however, that adherence to these rules will guarantee takes in all skin grafting operations. The surgeon's success will also depend on the kind of graft used and the area of the body surface grafted. Thiersch and split grafts, for example, will take on areas where full thickness grafts fail, and hence one must select the proper type of graft for repair of each condition. Infection is the most frequent cause of failure, and it is essential to take rigid precautions, both in sterilization of the operative field, and in operative technic, to guard against this complication.

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SCLEROSING OSTEITIS OF THE ORBIT

A CASE OF SCLEROSING OSTEITIS FOLLOWING PERFORATION OF THE EYEBALL BY A FOREIGN BODY

By BENJAMIN B. ADELMAN, M.D., Newark, N. J.

Case presented before the Academy of Medicine, Northern New Jersey, Eye, Ear, Nose and Throat Section

This condition is of sufficient rarity to be of interest to the medical profession. It emphasizes the importance of a complete history and the necessity of a careful examination for evidence of perforation by foreign bodies. The speed at which these foreign bodies strike the eye is so great that very often the injured is not cognizant of any trauma. We have all had occasion to examine eyes, which show on slit-lamp examination evidence of perforation without history of injury.

A boy, V. C., age 12, appeared at my office with a history of bulging of the left eyeball for the past three and one-half years. History revealed: At the age of two, while at play, he was struck in the eye with several particles of macaroni. The eye became red, and he was taken to a physician, who instilled drops. Within the next week the mother noticed a white spot in his pupil, and she again visited a physician, who informed her that the boy had a traumatic cataract and immediate operation was necessary. She consulted several ophthalmologists and then at the end of six months was told that the eye nerve was dead and that operation was unnecessary. Periodic examinations by competent men revealed no further developments. Three and one-half years ago proptosis of the left eye was observed. This condition became more pronounced, and in May, 1933, he appeared at my office. On examination, I found a well developed boy of 12 years, intelligent and alert in manner. The skull was quite large, no bony protuberances nor a head tilt were observed. There was a marked proptosis of the left eye downward, forward and outward. A hard mass was palpated under the supra orbital ridge. Motility of the left eye was distinctly limited in range and in all directions. Movements of the lids showed lagging. The left conjunctival sac was pale. Slit-lamp examination revealed that the left cornea was clear and transparent, except in the upper portion, where a small linear infiltrate extending through all the layers of the cornea was seen. The anterior chamber was of normal depth. The iris did not react to light, but dilated completely with atropine. There was a synechia extending from the iris to a small pigment spot on the anterior capsule of the lens, which was completely opaque. There was no perception or projec-

tion of light or color. Tension of the eye was normal. The right eye was negative for pathology. A diagnosis of perforation of the eyeball was made on the basis of a linear scar in the cornea, a traumatic cataract, and osteoma of the orbit. The patient was sent to Dr. Greenwood for x-ray examination, who reported the following:

"Examination of the radiographs of the left orbit shows a dense mass arising from the roof and medial aspect of the orbit and occupying about one-fifth of the orbital cavity. The mass surrounds a soft area about one-half inch in diameter which contains several small particles of metallic density."

The presence of the metallic bodies in the bone mass, the well-defined circumscribed nature of the mass, the linear scar through the cornea and the traumatic cataract led to the conclusion that the condition was a sclerosing osteitis following perforating injury. The question of malignancy was discussed because of the rarified area in the bone mass, although this was compatible with cystic osteoma. Operation was advised after consultation with Dr. Eagleton. He performed a modified Kronlein through the lateral aspect of the orbit. This brought the bone mass into clear view. With the drill, the mass was cut away, and in the heart of the mass was a pocket of pus, thick yellowish in color, with no distinctive odor. After the pus was evacuated, two small metallic objects were seen embedded in bone. These were removed; the orbit cleaned thoroughly, and the incision closed. Convalescence was normal, and he was discharged from the hospital in two weeks. He visited my office in August, and examination revealed that the incision had healed nicely; proptosis, although not entirely gone, was diminished. However, the surprising thing was that the boy claimed he could see light with the left eye. There was true light perception but false color projection.

Repeated examinations showed, without the possibility of a doubt, that there was definite improvement in light perception and projection, but true color projection central only. It was thought extraction of the opaque capsule would give some promise of useful vision. I performed a capsulotomy with complete iridectomy, with no untoward results. Convalescence was normal, and his light perception and projection improved. Color perception showed no improvement. However, he is able to see hand movements at 1 meter in all directions. The retinal vessels are rather attenuated. The disc is pale and sharply outlined. There are a few small floating opacities in the vitreous.

At the last examination, January 15, 1934, the following were noted: There is still a moderate degree of proptosis with a slight convergence. The eye is pale and shows no acute pathological change. The external margin of the orbit has filled in. Hand movements are seen in all quadrants at 1 meter, and color perception and projection has improved.

This case history serves to demonstrate the chronicity of an osteitis caused by the perforating foreign bodies. There is no doubt in my mind but that this boy received a rather severe injury with metallic bodies, and the blow with the macaroni was purely coincidental. The presence of the foreign body and the resultant periosteitis caused a sclerosing osteitis. The remarkable thing is that this boy was symptom-free for approximately seven years, and the first symptom was just proptosis. There is no history of headache or pressure symptoms.

I have made a rather thorough search of the literature, and I can find no similar case on record. Dr. Eagleton also tells me that he has seen no similar abscess.

CARE OF THE TEETH IN PREGNANCY

By Arthur W. Bingham, M.D., F.A.C.S., East Orange, N. J.

Read before The Essex County Dental Society, November, 1933, and before the Section on Obstetrics and Gynecology of the Academy of Medicine of Northern New Jersey, November 1, 1934

The care of the teeth during pregnancy is receiving more and more attention but opinions seem to differ considerably as to just what procedure should be followed.

Many physicians and dentists believe they solve the problem by prescribing calcium and viosterol for every patient. After studying a large number of obstetrical cases for many

years, I have found that the important factor is to get the patient in as good general condition as possible and keep her there.

The subject involves: First, the preservation of the teeth of the pregnant woman and the proper formation of the teeth and bones of the infant; second, the effect of infected teeth on the course of the pregnancy.

It is universally thought that both childhood and maternity are periods of an unusual susceptibility to dental caries. The old saying "A tooth for every child" is familiar to all but is not as true today as formerly. The period of lactation is thought to be quite as susceptible a period as that of pregnancy. Some authorities claim that pregnancy has no effect on the teeth and this is probably true when proper prenatal care is carried out. However, it would seem to be a safe precaution to give some attention to the care of the teeth during pregnancy and lactation.

During the growth of the infant, there is an abnormal demand for calcium for both tooth and skeleton building. When the nutrition can not supply ample calcium for the immediate demands, the essential constituents are taken from the mother's own system; thus, the foetus gains at the expense of the mother. It is important, therefore, to maintain the proper calcium balance in the system to prevent a drain on the pregnant woman. It is not sufficient, however, to simply take an additional quantity of calcium and phosphorus.

There are important factors governing calcium metabolism, such as the vitamins which assist in the absorption of calcium. The endocrine glands, especially the parathyroid, also help to regulate the calcium balance. Milk is the best food to be taken to help maintain the calcium ratio. A liberal intake of vitamins is also necessary for the utilization of the lime. Fruit, green vegetables, eggs, cod-liver oil, and viosterol are valuable aids in conserving the teeth of the mother.

Some authorities claim that dental caries is due entirely to an acid condition of the mouth and cannot be caused by any lack of calcium. Others claim that the mouth is no more acid during pregnancy and lactation than at any other time. If the enamel has no blood vessels, it is hard to understand how it can lose its calcium for the purpose of suppying material for the development of the foetus. If more calcium is needed than is supplied by food, the bony structure of the mother suffers.

We do know that an acid condition of the mouth will affect the enamel and so prescribe an alkaline mouth wash to be used frequently. This is especially important in cases of nausea and vomiting of early pregnancy. The acid gastric juice acts directly on the teeth in these cases and must be neutralized by the frequent use of an alkaline mouth wash. It has been demonstrated that bacteria cannot penetrate enamel that is intact.

While all will agree that these facts are well known, there is another important factor to be considered and that is the general condition of the patient. People who are not well are apt to develop carious lesions due to the lack of nutrition in the deeper structure of the teeth. This caries may be arrested when health is re-established.

For many years I have made an effort to improve the metabolism of the patient during pregnancy with the result that the patients have much less dental trouble than formerly. It is useless to load up the patient with calcium, phosphorous, and viosterol if her metabolism has broken down. The teeth will then deteriorate in spite of calcium, viosterol, and mouth washes. It is most important to keep the patient in good condition, maintaining the normal metabolism through exercise and diet; and, if this is done, only a few patients will require extra calcium as the majority will obtain a sufficient amount from their diet. A moderate amount of milk should be taken and a liberal supply of green vegetables with carbohydrates reduced to a minimum.

In watching the weight of cases of pregnancy over a long period, it became apparent that most of the patients who gained much weight or gained too rapidly had more complications than those who gained only moderately. The study of a considerable number of cases has proved that in general a patient who has gained weight only moderately and who has exercised in the open air will seldom

show signs of toxemia unless the kidneys were damaged before pregnancy took place.

The control of weight cannot as a rule be accomplished simply by diet. It is necessary to have the patient exercise in the open air. Many patients tell us they have so much to do about the house that they do not need to walk. This housework does not take the place of a walk in the open and a short walk should be urged for such patients after the first three months. Walking in the open improves metabolism better than anything else these patients can do, and by improving metabolism there is less toxemia, anemia, and dental caries. Patients in the wards are apt to show more anemia than private patients: partly, because they do not always get the right food; but, mainly, because they are working in the house all day and do not get sufficient exercise in the open air.

What is overweight in pregnancy?

The average woman of medium size should not gain more than fifteen or twenty pounds during her pregnancy. Stout patients should gain less and tall patients may be allowed a few pounds more. The weight should not increase quickly, as a sudden gain will frequently precipitate an attack of toxemia although the total gain may not be excessive.

The regulation of weight by diet and exercise accomplishes several things, but what interests us now is that it helps to prevent toxemia and anemia by improving the metabolism and thus also helps to preserve the teeth.

How is this regulation of diet and exercise managed? Each patient is handled individually depending on her weight, height, normal blood pressure, and past history. However, the details are too extensive to include in this paper.

How do we know that a patient's calcium metabolism is failing? There are blood tests which will show a deficiency in calcium but there may be a deficiency long before it shows in the blood for the blood will take it from the bones. There are several symptoms which indicate the need of more calcium. These are: Insomnia, unusual irritability of patient, cramp-like or aching pains in the legs and thighs, edema of the extremities not associated with heart or kidney disease, numbness of the extremities affecting large areas or in some cases only the fingers or toes.

If these symptoms occur in a patient apparently in good condition, an extra amount of calcium should be given as well as viosterol. It will thus be seen that the maintainance of the calcium ratio is not a simple matter and requires the attention of the attending physician from the beginning of pregnancy.

Let us consider the effect of infected teeth on pregnancy. Focal infection has been definitely proved to be an etiological factor in pernicious vomiting of pregnancy, miscarriage, pyelitis, phlebitis, anemia, and toxemias of pregnancy. Another point to be considered is the effect which bad teeth have on digestion whether from a mere inability to masticate properly or from swallowing the infected saliva. A full x-ray should be taken in all doubtful cases.

The extraction of teeth should not be undertaken lightly, and should not be done without the attending physician's advice. It is not advisable to extract teeth during the early months of pregnancy unless absolutely necessary. A miscarriage has often been caused by the extraction of a tooth. The danger is most marked during the first three months. As a rule, the teeth should be put in as good condition as possible without being too radical.

The choice of an anaesthetic in cases of pregnancy should depend on conditions found in each individual case. As a rule, a local anaesthetic is safer than nitrous oxide gas; although, if the patient takes gas well, there may be no objections if the condition of the gums make it unwise to use a local anaesthetic. The patient's physician should be consulted.

CONCLUSION

In order to preserve the teeth in good condition during pregnancy and provide sufficient calcium for the infant, the following suggestions are made:

1. Maintain a healthy metabolism by diet and exercise using gain in weight as a guide. This must be regulated by the physician according to the needs of the individual case.
2. Use an alkaline mouth wash after brush-

ing the teeth after eating, and at bed time.

3. In special cases give calcium alone, or calcium and phosphorous, or calcium phosphorous and viosterol.

4. Inspection by a dentist should be made at intervals throughout pregnancy when the teeth should be cleaned and all cavities filled.

5. Infected teeth should be treated promptly but conservatism should be used in regard to extractions.

INFECTION, SUSCEPTIBILITY, AND VACCINATION IN ACUTE ANTERIOR POLIOMYELITIS

By John A. Kolmer, M.D., Philadelphia, Pa.

Abstract of a paper presented before the Atlantic County Medical Society, February 8th, 1935

In this paper Dr. Kolmer presented in summary the studies leading to the development of an effective vaccine for the prophylaxis of infantile paralysis, describing the vaccine and the method of its administration, and summarizing the results proving its efficiency and safety.

Since acute anterior poliomyelitis is a virus disease in which the rarity of second attacks suggests the production of a lasting immunity; and since the majority of viruses appear to be highly immunogenic, the development of a safe and efficient vaccine is the most promising method for the prevention of this disease.

Several facts indicate the importance of inducing immunity to the disease.

1. The disease appears to be increasing in frequency.

2. The mortality varies, but is high (7.3-43 per cent).

3. There is a high percentage of residual paralyses (25-45).

4. There is a large number of individuals whose blood is devoid of antiviral antibodies as shown by many studies (79.2 per cent of children under 4 years; 45.5 per cent from 5-14 years old; and 24.7 per cent of those over 15 years), indicating that in all communities there is probably a high proportion of susceptibles, especially among children under 10 years of age.

The essential necessity for an efficient vaccine becomes obvious from the fact that not all convalescent sera are fit for prophylactic or therapeutic use, from 12-63 per cent, with an average of 30 per cent on actual trial showing no antiviral antibody content.

That second attacks are rare, despite the data just given, suggests that tissue immunity develops, and resistance may be present even though antiviral antibodies cannot be demonstrated in the serum. Such tissue immunity may be due to subclinical unrecognized attacks; or, as has been suggested, it may be a "maturation immunity" dependent upon physiological factors or endocrine functions, but these cannot be relied upon for efficient prophylaxis since the disease frequently occurs before they have had time to bring about resistance.

Dr. Kolmer's experiments indicate that:

a. A vaccine of passage virus is effective against human virus.

b. "Dead" virus, though weaker than attenuated virus, may be effective.

c. The dead virus must be concentrated to reduce tissue protein reactions and the necessity for elaboration by the body of protective mechanisms against such proteins.

d. Fine suspensions of cord tissue are desirable in order to secure the maximum of intracellular virus for immunizing purposes.

THE VACCINE

Dr. Kolmer's vaccine is prepared from a remote passage strain of the virus which apparently has lost most, if not all, of its human infectivity, the spinal cord being used because of its greater virus content as compared to brain tissue. The vaccine is still further devitalized by the addition of sodium ricinoleate, the mixture being allowed to stand from two weeks to one month. Attenuation is stopped by refrigeration at 4° C. Vaccines a year old show no change in infectivity for the monkey,

nor in vaccinogenic activity. Bacterial contamination is guarded against by careful aseptic technic throughout in the preparation of the vaccine, by allowing the cords to stand for one month in 50 per cent glycerine in saline, and by strict cultural control of the completed vaccine. As now made, the vaccine consists of 4 per cent cord suspension in 1 per cent sterile solution of sodium ricinoleate.

ADMINISTRATION

The vaccine is given by subcutaneous hypodermic injection in a series of three doses at weekly intervals.

It has now been given to a relatively large number of children and adults, among the first being Dr. Kolmer himself, Miss Rule, his assistant, and his two sons.

There has never been the slightest ill effect, marked, and usually mild. Occasional mild Local reactions of varying degree occur, never temperature evaluations were seen (100.2° F. being the highest) returning to normal in 48 hours. In some of the children there was a slight absolute increase in the neutrophilic polys (500-1200 per c.mm.) in the first 24 hours which, very probably, may be ascribed to the local reactions, as these varied pari passu.

It is possible that the dose interval may be increased with added effectiveness.

DOSAGE

The following are the doses advised by Dr. Kolmer:

1- 3 years: 0.25 cc.; 0.5 cc.; and 0.5 cc.
4-10 years: 0.5 cc.; 0.5 cc.; and 1 cc.
11-15 years: 0.5 cc.; 0.5 cc.; and 1 or 2 cc.
Adults: 0.5 cc.; 1 cc.; and 2 cc.

RESULTS

While neutralization studies have shown that demonstrable antiviral antibody production may occur after even one or two doses, two and preferably three doses are advised. Antibodies have been demonstrated as early as 48 and 96 hours after vaccination, in, of course, varying amounts.

This suggests the usefulness of vaccination during epidemics, especially as there does not appear to be any "negative phase" or period of increased susceptibility after the administration of the vaccine.

It is possible that still greater antibody production may follow ten-day intervals between the injections.

Neutralization tests after vaccination demonstrate the presence of antiviral antibodies in 75 per cent of children whose blood before vaccination had no protective power, these children, moreover, being convalescent from various medical and surgical conditions and perhaps thus not being as well prepared to produce antibodies as healthy children.

Antibody production was even more marked in children whose blood before vaccination contained antibodies, possibly because their tissues were sensitized or "tuned up" by unrecognized previous virus infection, and so were more practiced, as it were, in antibody production to poliomyelitis virus.

GENERAL EFFECTIVENESS

Experiments indicate that the poliomyelitis virus apparently may not exist in immunologically specific strains; and so Kolmer's vaccine will probably be effective in all localities.

WHO SHOULD BE VACCINATED?

If the patient can afford the expense involved in the conduct of serum neutralization tests these can be relied upon as detecting susceptibles.

Since about 80 per cent of children under four years are susceptible, tests are not necessary in this group.

As the vaccine has been shown to be both safe and efficient, vaccination in older children and adults may be a matter of choice; but it may justifiably be advised by the physician, especially in epidemics.

Since there appears to be an important heredity predisposition to the disease, the vaccination of children in families where the disease has appeared is particularly important.

DURATION OF PROTECTION

The duration of immunity cannot yet be stated exactly, since the vaccine has only been recently developed; although vaccinated monkeys are still insusceptible to intracerebral inoculations with virus 3 years after the injections.

Even if it eventually develops that the immunity lasts only long enough to protect children through their susceptible period and until "maturation immunity" has developed, the method is of inestimable value.

DISCUSSION

In opening the discussion, *Dr. Robert A. Kilduffe* commented upon the fact that ignorance and fear go hand in hand and that poliomyelitis is a potent source of panic hysteria because we know but little about it. It is true that we speak of its cause as a filterable virus, which term, however, really only hides the fact that the nature of these viruses is still not clear. We know something of the portals of invasion; but little of the actual mode of dissemination of this disease; and in the face of its terrible aftermath we are practically helpless to control it, treat it, or correct its results. Immune and normal serums are of problematical value.

Under these circumstances the idea of an effective prophylaxis by vaccine has long attracted investigators, and vaccines have been prepared by several. The killed virus apparently has relatively little vaccinogenic value. While it was found possible to create immunity to poliomyelitis in monkeys with weak or attenuated vaccines, unfortunately occasionally the same vaccines produced not immunity but the actual disease, thus precluding their use in human beings.

The essence of Dr. Kolmer's achievement is that he has discovered not only an immunogenic vaccine, but one which is *safe*. He has therefore made a discovery which gives promise that the answer to the effective prophylaxis of poliomyelitis may be at hand: and, in turn, that this disease, too, will become one more of the triumphs of modern medicine.

Continuing the discussion, *Dr. Harold S. Davidson* commented on the apparent increase in the incidence of poliomyelitis as indicating the great ous way.

Dr. Allan Brown, of the teaching staff of the Toronto Medical School, expressed the interest with which he had heard the story of the studies leading to the discovery of Dr. Kolmer's vaccine. He also discussed the Dionne quintuplets in a humorboon that Dr. Kolmer's discovery confers.

LYMPHOGRANULOMA INGUINALE

By HERBERT S. TALBOT, M.D., East Orange, N. J.

Read before the Essex County Anatomical and Pathological Society, November 22, 1934

There can be little reasonable doubt that the syndrome now generally known as *lymphogranuloma inguinale* constitutes a specific disease entity which is transmissible, and practically always transmitted by venereal contact. Although only in recent years has the literature become fairly abundant, it is probable that the disease is not a new one. Inguinal buboes of various types, however, are so common in medicine, and have been so frequently discussed throughout its history, that it would seem futile to attempt to establish a specific diagnosis in any of the early cases. Early in this century the term "climatic bubo" appeared, and from the pathological descriptions then published, one may assume that at least some of these cases are what we call lymphogranloma inguinale.

It remained, however, for Durand, Nicolas, and Favre to describe the condition in detail and insist upon its specificity. In 1925 Frei introduced a skin test for its accurate diagnosis. Since then, reports have appeared more frequently, of larger series of cases, and including a wide variety of clinical manifestations, all of which are claimed to be hitherto unrecognized or incorrectly diagnosed aspects of the same disease.

COURSE OF THE DISEASE

It would appear to be of some value briefly to examine the evidence which supports the identification of these various clinical and pathological manifestations with a single morbid process. The primary disease has been so well described as to be easily recognized, even without a skin test, in most instances. Characteristically, there is an ephemeral primary lesion, and a subacute inflammation of the regional (usually the inguinal) lymph nodes. Suppuration occurs at a number of sites, the nodes become attached to the overlying skin, and more or less permanent fistulae result. In the male the primary lesion is usually situated on the glans, on the prepuce, or in the urethra. De Wolf and Van Cleve mention four characteristic types of primary lesion: (1) The ulcerated type; (2) the nodular type; (3) the

papular type; (4) lymphogranulomatous urethritis. In the female the primary lesion may be situated at the introitus, but more often is located on the cervix or the vaginal wall. It is this fact which led to the belief, prevalent for some time, that the disease does not affect females as frequently as males.

Studies of larger series of cases indicate that this disparity between the sexes is more apparent than real, in that, with a primary lesion within the vagina, the inguinal nodes are not within the radius of lymphatic drainage and are therefore not infected.

The incubation period is said to be from ten to thirty days between the time of the exposure and the appearance of the inguinal adenitis. It is difficult to say how long a time elapses between the exposure and the appearance of the primary lesion, because the latter usually disappears spontaneously in a few days, is often not noticed by the patient, and is hardly ever seen by the physician. In a general way, however, it may be stated that two or three weeks elapse between the appearance of the primary lesion and the beginning of the adenitis. This then progresses steadily but slowly. Sometimes there will be a spontaneous remission with shrinkage of the size of the involved nodes, although they always remain enlarged to a certain extent. Such remissions are usually temporary and are followed by an increase in the size of the gland, attachment to the skin, and ultimately suppuration.

The subjective symptoms are generally not marked. Although cases have been reported in which mild constitutional symptoms were present, they are usually absent, and the patient presents himself complaining only of a moderate tender swelling, or if the disease has reached this stage, of draining sinuses. Untreated, the tendency of the disease is to run a chronic course, leading eventually to destruction of the lymph nodes and healing with contracture and scarification. If this is sufficiently marked, *elephantiasis* may be a sequel.

In women the disease probably localizes mainly in the lymph nodes which lie within the pelvis, and therefore may give no early external evidence of its presence. Careful study of these cases and their sequelae has suggested an explanation for the protean character of the disease, and justification for including among its manifestations certain clinical features which might at first appear to bear no relation to the primary infection.

These include chronic ulcerative elephantiasis of the vulva (*esthiomène*), similar lesions of the male genitalia, rectal stricture in the female, anal ulcerations or fistulae with more or less elephantiasis, and chronic perimetritis or perisalpingitis, with or without intrapelvic abscess formation. The whole group has been described as the genito-ano-rectal syndrome, and the conception of this syndrome as a manifestation of *lymphogranuloma inguinale* requires reference not only to the etiology, pathology, and pathogenesis of the disease, but to the anatomy of the involved parts as well.

FREI TEST

Superficially, one notes that all these cases show a positive Frei test, which consists of the intradermal injection of an emulsion of sterilized pus from an active case. But it is questionable whether one may accept a test of skin sensitivity as a sufficient proof of the diagnosis of a clinical entity, helpful though the procedure may be in a practical way. Nor can we depend upon the demonstration of a common etiology in order to relate the various manifestations to each other. Ultimately, reliance must be placed in a study of pathology and pathogenesis.

VIRUS

The etiology is, as a matter of fact, obscure, but there is little doubt at present that the disease is the result of infection by a specific filterable virus. Tamura claims to have been successful in cultivating this virus, and securing with filtrates skin reactions similar to those produced by emulsions of pus such as are customarily used for antigen. Levaditi and others have made extensive investigations of the effect of the virus upon animals, and, in one case, upon a human. Although absolutely characteristic lesions are not always produced, Hellerstrom did succeed in producing in monkeys

a meningo-encephalitis which is apparently specific. The work done up to the present seems to indicate that the disease is caused by a specific virus which is distinctly lymphotropic.

PATHOLOGY

Characteristic and recognizable histological changes can be demonstrated most easily in a lymph node removed before secondary infection has set in. The essential lesion is a micro-abscess lined by one of two layers of epithelioid cells in palisade arrangement. Occasional giant cells occur, as well as certain masses of substance taking a chromatin stain, the significance of which is not yet known, but caseation and calcification do not occur. The primary lesion shows the same changes, and so does the skin lesion of the positive Frei test.

In considering the secondary manifestations of the disease, it is necessary to investigate its pathogenesis. It has been noted that the virus is essentially *lymphotropic*. A study of the lymphatics of the genito-anal region in the male and female, and their connections with the intrapelvic lymphnodes, particularly in the latter, will make clear that a variety of lymphatic lesions is possible. In these conditions the characteristic pathology of the disease is no longer apparent, having been obscured by secondary infection, scarification, and fibrosis. In other words, they represent an end stage of the process, rather than the process itself. Consequently they are less amenable to any form of therapy, and emphasize the desirability of early diagnosis.

The treatment of lymphogranuloma has been discussed in a previous communication. (Public Health News, Jan., 1935, p. 344.) Since then, personal experience seems to have confirmed the hope expressed at that time—namely that specific treatment by means of injecting emulsions of the pus intracutaneously is capable of controlling the disease in its early stage. But many more cases must be studied before this can be set forth as more than a hope and an impression.

CONCLUSIONS

1. Lymphogranuloma inguinale is a specific disease which is transmissible and practically always transmitted by venereal contact.

2. It is caused by a specific filterable virus which is capable of reproducing analogous lesions after repeated animal passages.

3. This virus is distinctly lymphotropic.

4. The characteristic lesion is a nodule of epithelioid and giant cells, with a central necrotic core and surrounded by a pleomorphic cellular infiltration.

5. In its later manifestations, the disease includes the characteristic, although histologically non-specific, lesions of the genito-ano rectal syndrome.

6. The development of these lesions is conditioned by the site of the original lesion, the lymphatic drainage of that site, and by the presence or absence of secondary infection.

7. In practice, the diagnosis can generally be made on the basis of a positive Frei test, supported by a careful history and physical examination.

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RECOGNITION OF SPIDER BITES

A CASE REPORT

By E. H. Rohlfing, M.D., and B. M. Bullington, M.D., St. Louis, Mo.

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EDITORIAL NOTE

The July issue of this Journal, page 401, carried an editorial on the identification of a "Black Widow" spider in a backyard of Trenton. A short time afterward the daily papers featured a news item that a collector for a manufacturer of biological supplies had secured hundreds of the spiders in the City of Philadelphia to be used in making an antitoxin against their poison.

The symptoms of a spider bite are characteristic, and are like those of an "acute abdomen". A brief description of an ordinary case is given so that the family physician will have the possibility of a bite vividly in mind when he is called to a case of acute abdomen.

The following typical case is reported by Dr. E. H. Rohlfing and Dr. B. M. Bullington, St. Louis, Mo., in the July issue of the Journal of Pediatrics, page 79. *(Copyright by the C. V. Mosby Company, St. Louis, Mo.)*

W. M., a white male three years old, was seen (by E. H. R.) at 4:00 p. m. and immediately referred to St. Louis Children's Hospital. The history was as follows: About five hours previously the child was bitten by an insect which the parents killed and found to be a "black spider which had a red belly". The child was bitten as he carried a sprinkling can in the yard around the flower beds. The bite produced considerable discomfort, and soon an area of redness appeared around the site of the injury. There were no other complaints at this time, and the child pursued his usual activities until about one and one-half hours later, when he suddenly began to complain of a severe, constant, agonizing pain in his abdomen which soon "doubled him up". There was no nausea, vomiting, convulsions, or fever. The mother gave the child an enema, which was expelled clear and afforded no relief. Since the onset of the abdominal pain, there had been little change in the boy's condition.

The family and past histories were not significant, except that the child had been in "good health" until his present illness. Physical examination showed a three-year-old boy, lying in bed, acutely ill, with his knees and thighs flexed on his abdomen. He was quite restless, and complained of a severe constant pain throughout his abdomen and a milder discomfort in his right forearm. On the dorsal surface of the right forearm there was an erythematous, raised area about the size of a silver dollar. There was no lymphadenopathy, or evidence of lymphangitis.

His temperature was 37° C.; respirations, 44 per minute; pulse, 120 per minute.

The examination of the head, eyes, ears, nose, and mouth showed nothing abnormal except moderately dilated pupils, which reacted to light and accommodation. His respiratory movements were rapid, entirely thoracic, shallow, accompanied by an expiratory grunt, but without dilatation of the alae nasi. The chest was clear. The heart was not enlarged; the sounds were of good quality, regular in rate and rhythm. The abdomen was flat and possessed a boardlike rigidity throughout. Palpation produced no additional discomfort, and because of the rigidity none of the viscera could be palpated. No free fluid could be detected. The reflexes were normal except for the presence of slightly hyperactive knee jerks and biceps. No Babinski, Chaddock, Oppenheim, Gordon, Hoffmann, Kernig, or Brudzinski reflex was elicited. There was no neck nor back rigidity detected.

Laboratory Data.—Red blood cells, 4,900,000; hemoglobin (Sahli), 90 per cent; white blood cells, 19,000. Differential count—Basophiles, 0; eosinophiles, 0; lymphoblasts, 0; myeloblasts, 0; myelocytes, 0; juveniles, 0; stabs, 14; segmenteds, 64; lymphocytes, 18; monocytes, 4. No parasites nor punctate basophilia was seen.

Urine: The reaction was alkaline to litmus; sugar, 0; albumin, 0; ketone bodies, 0; specific gravity, 1025. Microscopic examination revealed an occasional white blood cell, no red blood cell, occasional epithelial cells, and no casts.

Temperature ranged from 37 to 37.5° C.

The treatment in this case was magnesium sulphate as used by De Asis, except that we used the intramuscular route. Ten cubic centimeters of a 25 per cent solution of magnesium sulphate was given intramuscularly in the gluteal regions. Elixir of sodium phenobarbital was given in amounts of 4 c.c. every four hours for three doses. Following this medication, the child rested fitfully through that night. The next morning he was physically improved; he had less pain and a fair appetite, but some abdominal rigidity was still present. His recovery was rapid, and he was discharged from the hospital after twenty-four hours. At the end of forty-eight hours the abdominal rigidity had entirely disappeared, and the child was quite well again. At the time of discharge his white count was 17,600 with a differential count of stabs, 7; segmenteds, 55; lymphocytes, 32; monocytes, 6.

STATE SOCIETY ACTIVITIES

THE A. M. A. MEETING AND THE STATE JOURNALS

The eighty-sixth annual meeting of the American Medical Association, held in Atlantic City, N. J., June 10-14, 1935, was so extensive and its features so varied that no one person could estimate their value or the extent of their influence. Reliable evidence of their effect is the amount of space which the official State Medical Journals devoted to the meeting, and the parts of the program which they discuss.

About half of the State Journals feature the A. M. A. meeting. The most common topic mentioned was the presence of doctors of the particular state, and the official recognition given to its physicians.

The features of the meeting which impressed the Editors and Publication Committtees of the several States are indicated by the following extracts from the State Journals:

TEXAS

The annual message of Dr. S. E. Thompson, President of the State Medical Association of Texas, delivered before the House of Delegates of the State Society of May 13, 1935 (*Texas Jour., June, p. 80*), contained the following remarks in anticipation of the coming meeting of the A. M. A.:

"The average doctor apparently knows little about our parent organization, and probably cares less.

"It is the largest and most influential medical organization known to man.

"It is the most democratic organization in existence.

"My attendance at a regular and special meeting of the House of Delegates of the American Medical Association has convinced me that the states wielding the most influence are those which year after year select and return as delegates their most active and influential members. For this reason, I suggest you select your delegates, keeping before you the idea of influence and efficient service; and that a majority of your delegates so selected be returned year after year."

The Texas State Society has consistently followed this policy by sending its Secretary-Editor, Dr. Holman Taylor, as one of its delegates. His leading editorial in the July issue of the *Texas Journal,* describing the A. M. A. meeting, contains the following appreciation of the hospitality of the physicians of New Jersey:

"The entertainment features of the occasion were more than ample, evidently quite pleasing. The Canadian Association entertained the officers of the American Medical Association and its Board of Trustees at a luncheon, presenting to the Association a gavel of special and unique design, as a memento of the occasion.

"The medical profession of New Jersey tendered a dinner and entertainment to the House of Delegates and officers of the American Medical Association, at which the official part of the Canadian Association were guests. The occasion will long be remembered by those who were present. Whatever else we may say about our professional brethren across the line, they enjoy their pleasures, and are pleased with their enjoyment. In every particular the profession of Atlantic City and of New Jersey sought to make visiting physicians feel thoroughly at home, and to see that they enjoyed their stay in the playground of America."

MICHIGAN

The July issue of the *Journal of the Michigan State Medical Society* contains a two-page estimation of the A. M. A. meeting written by the Secretary, Dr. Burton R. Corbus, in which he said:

"It seemed to your observer, as he conversed with various members on the evening before the first session of the House of Delegates, that there was evident an attitude of mind that is perhaps best expressed by the phrase, 'Where do we go from here?' It was an attitude which, apparently at least, persisted throughout most of the session.

"The economic problem was much in the minds of the delegates—the President's Social Security program a frequent topic of conversation. Yet, Dr. Leland's excellent and most informative report from the Bureau on Medical Economics apparently bored the House and it was sent to the Reference Committee only partially read.

"Dr. C. Henshaw Kelly made a telling and well-received speech in explanation of California's attitude and the occasion for California's sponsorship of the insurance bill before its state legislature.

"Later the House indicated definitely that California was not fully restored to its good graces by refusing to elect the California candidate for member of the Board of Trustees, and not fully satisfied with this bit of discipline, by a narrow margin defeated Dr. Warnshuis, who has been Speaker of the House for thirteen years.

"Dr. Carl F. Moll, Flint, Michigan, a candidate for a vacancy on the Board of Trustees, lost to Dr. James R. Bloss, of West Virginia, and some Michigan doctors wonder if his defeat could possibly have been contributed to or was influenced by Michigan's vigorous insistence at the Cleveland Session that a definite policy in regard to health insurance be promptly set up.

"A pleasant Virginian, James T. Mason, who transplanted himself to Seattle, Washington, where he became one of the leading surgeons of the Northwest, was made President-Elect.

"The activities of the House of Delegates were not especially noteworthy. With monotonous regularity, the reports of Reference Committees were adopted without discussion. To some this seemed to indicate a substantial unanimity of opinion; and again to others it suggested that this unanimity arose out of a certain confusion of thought or of a lack of sufficient preparedness to intelligently discuss the subject before the House."

NEW YORK

The July first issue of the *New York State Journal of Medicine* carried a column editorial on the A. M. A. meeting, as follows:

"To listen to the comment current among the physicians in attendance, it would seem that the scientific exhibit was taking a more important place in their estimation of the scientific sessions. Here the clinician and the research worker come together in the true sense of the word, and in a totally informal way they discuss the problems interesting them: and both leave with ideas clarified and with a better comprehension of relative limitations, and an added mutual respect for each other's fields of endeavor.

"The concern of the A. M. A. with the social aspects of medicine is natural. This great body of physicians attunes itself to community sentiment. It has declared itself against compulsory health insurance and against socialized medicine in general. The reasons which prompt this stand have been detailed too often to need repetition here. On the other hand, just as our State Society has done, the A. M. A. has declared its willingness to coöperate in suggesting how medical service can be provided for those who find themselves confronted with financial barriers which prevent them from procuring adequate medical services. Today, medicine is the outstanding social science. As such, the A. M. A. is taking its rightful place in guiding and directing this important service to the American people."

THE NORTHWESTERN STATES

The July issue of *Northwest Medicine,* the official Journal of Oregon, Washington, and Idaho, chose the report of the Bureau of Economics as its subject of comment, and said:

"The Bureau of Economics reported that there are now in operation over 200 local bureaus for the care of the low income brackets of people. They had information concerning all these plans, but had no plan to offer as a substitute for the present system of the practice of medicine. However, they would gladly give advice and information to any local society that wanted to set up an organization for the care of the lower income groups of people."

VIRGINIA

The July issue of the *Virginia Medical Monthly* gave only a quarter of a page to the A. M. A. meeting, choosing contraception as its subject for comment and saying:

"The American Medical Association has finally got round to appointing a committee to determine what position the Association should take concerning the question of birth control. Whether this action on the part of the Association has any bearing upon the attitude the Medical Society of Virginia should take is a matter for its officers to decide. It must be apparent from a recent poll taken by the *Monthly* and the activity of several birth control clinics in the State that the medical profession of Virginia is overwhelmingly in favor of the principle of birth control. Whether or not organized medicine in the State recognizes its obligation to furnish leadership for the movement the fact remains that doctors as individuals are already actively engaged in the practical application of this important, and in many cases necessary, procedure."

MISSOURI

The page of statistical comments on the A. M. A. meeting in the July issue of the *Journal of the Missouri State Medical Association* ended with the following paragraphs:

"Some of the actions of the House of Delegates were:

"Condemning state medicine and compulsory sickness insurance.

"Approving voluntary sickness insurance under control of the County Medical Society.

"The appointment of a committee to investigate birth control.

"Tightening the rules inhibiting solicitation of patients particularly in industrial practice and unfair competition of clinics and groups.

"Condemning unethical and unlawful practice of medicine by hospitals, dispensaries, insurance companies and universities."

LOUISIANA AND MISSISSIPPI

The impressions of the States of Louisiana and Mississippi are set forth in an editorial in the July number of their common organ, the *New Orleans Medical and Surgical Journal,* which chose the exhibits for comment and said:

"In addition to the opportunity of hearing papers, the visitor to one of these conventions has the chance of seeing an unrivaled scientific exhibit. There at his leisure the physician can see represented graphically or actually the results of certain lines of treatment, the effects of certain morbid changes in the body, the experiments in the production of disease conditions; in fact there is enough present in the scientific exhibit to keep the physician busy every day that the convention meets.

"Nor must there be forgotten a really splendid commercial exhibit where the physician has the chance of learning about the new drugs and new instruments, and looking over new books. While the commercial exhibit frankly is an appeal to the physicians pocketbook, nevertheless it gives him the opportunity of seeing the newer things in medicine which are for sale and which probably he would like to purchase only after he has had the opportunity of looking over these things."

NEBRASKA

Impressions from Nebraska were expressed in a two-page description by Dr. B. F. Baily, one of the delegates, who wrote in the *Nebraska State Medical Journal* for July:

"The House of Delegates is only representative and in no way can be efficient in accomplishment except by the serious effort and consideration of these same subjects by the component associations and individual members of the A. M. A.

"Attention was especially called to the package library service which is available to any member of the A. M. A. who is engaged in a literary investigation for his own advantage or for literary purposes. Any who have never thought of it will be glad to take advantage of this.

"The report of the Committee on Legislative Activities further says, 'No legislative committee can be stronger than the will of the profession and the professional will to stand together and fight the battle for the future of medicine. This sentiment must be inculcated in the minds of every doctor in this land.'

"The medical profession from time immemorial has come to have the care of the health and happiness of the people of our country more than any other organization. It has found its place in the affections of the people who have realized the kindly, scientific, persistent, never-ending efforts of the profession in the interest of the people.

"We believe that we labor under the banner of a divine power just as markedly as does the clergy; that we minister at the bedside of the newborn and at the bedside of him who passes to his reward; that we realize it is our duty now and evermore to so be bound together that no effort which is either thoughtless or selfish in its initiative be permitted to disintegrate us or take from us our self-control and the pleasure of our allotted duty to the public."

ALABAMA

Fraternity was emphasized in the description of the A. M. A. meeting approving editorially in the July issue of the *Journal of the Medical Association of the State of Alabama*:

"In some indefinable way, one could sense the sobering influences of British medicine wafted to our shores via the Canadian route; and in turn, one could equally sense the stimulating forces of American medicine brought into play upon the Canadian contingency. Evidence of these facts was conspicuous at the dinner given on Monday evening to the officers and delegates of both associations, when key-note addresses were made by representatives from both associations.

"Again it was emphasized on the Tuesday evening public session by many addresses from both sides, brought to a climax by the presentation of an address by the world renowned Dr. DaFoe, whose fame has found favor, because of a stubborn persistence on the part of a general practitioner to remain true to his charge, even though such charge appear in the nature of a multiplicity of infants arriving synchronously from a common source."

INDIANA

The *Indiana Journal* of July devoted more than two pages to a description of the House of Delegates of the A. M. A. An interesting comment was the following on last year's controversy between the A. M. A. and the American College of Surgeons in regard to economic policies:

"An event of especial satisfaction was the report of the Chairman of the Committee on Legislative Activities to the House of Delegates, that following a conference with the Chairman of the Board of Regents of the American College of Surgeons, the latter declared that the activities of the College of Surgeons would be confined to affairs of a scientific character. The Chairman of the Board of Regents agreed to write a letter to the President of the United States stating that the American College of Surgeons does not differ in sentiment from the American Medical Association; that it is not interested in the legislative affairs of the House of Delegates except to lend support to its principles, and that it recognizes the American Medical Association's right to speak for the organized medical profession."

COLORADO AND WYOMING

The July issue of *Colorado Medicine*, the official Journal of Colorado and Wyoming, commented on the A. M. A. meeting editorially as follows:

"Problems of the West occupied much of the time of the House of Delegates, and the association looked to the West both for its new President and its 1936 meeting place.

"The political tangle in which the California Medical Association involved itself during the past year, threatening the state with legislation for socializing the medical profession under political control, was laid before the executive session of the House of Delegates. Distrust of the judgment of California's medical leaders later evidenced itself in the defeat of all California candidates who were nominated for high office in the A. M. A. While eastern newspaper correspondents interpreted the elections as a 'spanking' for California, we saw it rather as an admonition to California to get her feet back solidly on the ground of sanity before seeking the privilege of leadership in the national organization. Hap-

pily, reports presented in the executive sessions indicated that saner movements are gaining ground in the big coast state already."

The Journal also commented on the fraternal spirit of the Canadian physicians, as follows:

"No comment upon the session would be complete if we failed to doff our editorial hat to those fine representatives of the Canadian Medical Association, and to the spirit of the association itself in sending to the meeting a proportion of its membership which the A. M. A. never has, and probably never will, approach."

PERCENTAGE OF ATTENDANCE

Regarding the proportion of the Canadian Medical Association attending the A. M. A. meeting, the Journal of the A. M. A. for June 29, page 2372, credits Canada with 303 physicians attending the A. M. A. meeting.

The A. M. A. Directory of 1934 does not state the number of members in the Canadian Medical Association, but it does give the number of physicians in each of its ten Provinces and Territories; and the total is 10,225. Therefore, three per cent of the Canadian physicians attended the A. M. A. meeting.

The number of physicians of the United States attending the A. M. A. meeting was 8166, which is five per cent of the 161,000 physicians recorded in the Directory.

New Jersey and the States bordering on it sent 19 per cent of the members of their State Societies to the A. M. A. These four States supplied 56 per cent of the number of physicians who registered from the entire United States.

REPORT OF BUREAU OF ECONOMICS OF THE A. M. A.

A special session of the House of Delegates of the American Medical Association met on Friday and Saturday, February 15 and 16, 1935, for the purpose of considering "The social and economic policies of the Association as related to pending and proposed legislation, to sickness insurance, and to other matters which may be submitted by the Board of Trustees." (Jour. A. M. A., March 2, 1935, p. 747.)

The House approved the plan that the Bureau of Medical Economics study the existing plans for the collective distribution of medical services that are now in operation and report its findings to the annual meeting of the A. M. A. to be held June 11-17, 1935. (A. M. A. Jour., March 2, 1935, p. 752.)

The Bureau of Economics made a report on the afternoon of June 11, the minutes of the House of Delegates reading:

"Dr. R. G. Leland, Director of the Bureau of Medical Economics, presented a special report, which was referred, without reading, to the Reference Committee on Medical Economics."

This report was approved and adopted. It was not printed in the Journal of the A. M. A., but appeared in full in the "Bulletin" of the A. M. A. for June, 1935, which reached the members during the week beginning July 22, 1935. The following is a brief analysis of the report.

The report of the Bureau of Medical Economics may be considered in two parts.

PART ONE

Part one is little more than an index of State and County Medical Societies which have "Plans operating or proposed for indigent and general medical care".

The following eleven states are listed as having plans:

Alabama
California
District of Columbia
Iowa
Michigan
Minnesota
New Jersey
New York
Rhode Island
Utah
Washington

No description of any plan or estimate of its value is given.

The following number of County Medical Societies are listed as having plans for the distribution of medical services:

California	9 counties
Florida	1
Georgia	1
Indiana	3
Iowa	55
Kansas	10
Kentucky	1
Louisiana	1
Michigan	6
Missouri	2
Nebraska	2
New Jersey	1

New York	6
Ohio	2
Oregon	1
Pennsylvania	8
South Carolina	1
Texas	6
Virginia	1
Washington	9
Wisconsin	6
Total	132

County Societies approving plans for prepayment of hospitalization:

Kentucky	1
Michigan	1
Minnesota	1
Ohio	1
Tennessee	1
Total	5

State or County Society plans for medical and hospital care in which the medical societies are active in the operation and control, all of which are merely proposed:

California	2
Michigan	1
Ohio	1
Rhode Island	1
Texas	2
Wisconsin	2
Total	9

In all there are 161 plans listed.

The report gives the following analytical table analyzing the methods:

A. Special Fee Schedule
For low income groups and those temporarily unemployed

B. Medical Care for the Indigent
Contract or agreement with proper officials of the political subdivision
1. Specified sum paid quarterly or annually
Examples: Marshall County, Iowa; Ringgold County, Iowa; Barton County, Kan.
2. Special fee schedule
Examples: Clinton County, Iowa; Waterloo County, Iowa; Franklin County, Kan.; Calhoun County, Mich.; Oakland County, Mich.; Northampton County, Pa.
3. Per Capita
Based on periodic adjustment of indigent load
Example: Johnson County, Iowa

C. Minimum Guarantee to Physicians
In communities not otherwise able to secure resident physicians
1. Part time health officer
2. General medical service, including care of indigent
3. Combined curative and preventive medicine supplemented by regular medical fees

D. Voluntary Budgeting for Medical Care
1. Post payment for medical care
a. Medical Service Bureau
Examples: Wayne County, Mich.; District of Columbia; Utah State Medical Association; Omaha-Douglas County, Neb. (Proposed)
b. Part pay or reduced fee
Based on social service investigation
Examples: Alameda County and Fresno County, Calif.
c. Central Medical Service
Social service and patient routing
Example: San Diego County, Calif.
2. Prepayment for medical care
Organized for industrial groups only or all persons below a stated annual income
a. Medical Service Bureaus. Examples: States of Washington and Utah; Fulton County, Ga.
b. Hospital Associations. Example: Oregon
c. Community Medical Service. Example: Milwaukee County, Wisconsin (Proposed)

E. Voluntary Budgeting for Hospital Care
1. Prepayment for hospital facilities only
Examples: Palo Alto, Calif.; Washington, D. C.; Wichita, Kan.; Associated Hospital Service of New York (proposed); Cleveland, Ohio

F. Special Services or Procedures
Coöperation with health department or other agencies
Examples: Wayne County, Mich.; New Jersey; Pennsylvania

G. Regulation of Hospital Clinic and Dispensary Admissions and Routing of Hospital Traffic
Examples: Cleveland; Philadelphia; Nassau County, N. Y.; Mound County, N. Y.; St. Louis

H. Industrial Group Service
Examples: Spaulding Bakeries, Binghamton, N. Y.

The report then gives a description of a typical example of each method that is listed in the table, listing twenty-three plans in operation from California to New York.

Part one of the report fills five pages of the Bulletin, and ends with the following comment:

"These plans involve in general the following steps:

"1. Study of local medical facilities to determine the nature and extent of medical problems for which adjustment is needed.

"2. Definition of persons or income groups for whom medical benefits should be provided.

"3. Method of determining patient's ability to pay.

"4. Amount and nature of medical service to be provided.

"5. Organization and coördination of community medical services, supplemented by new units of administration when necessary.

"6. Systematic movement of applicants for medical care.

"7. Manner of presenting a plan to the public and method of securing members.

"8. Method of making collection or receiving payments for medical care.

"9. Method of remunerating physicians for their services to patients receiving benefits under the plan.

"10. Administrative details."

PART TWO

Part two of the report fills six pages of the Bulletin, and consists of a discussion of the principles to be followed by a society undertaking to establish a system for distributing medical services. This part is concise and clear and is a valuable guide for any society forming a preliminary plan for a study of its proposed field of activity. Its scope is indicated by its paragraph headings as follows:

1. Careful Preliminary Study Necessary.
2. Person for Whom the Plan Is Intended.
3. Appraisal of Ability to Pay.
4. Amount and Nature of Medical Service to Be Provided.
5. Preventive Measures Should Be Included.
6. Organization of Community Medical Facilities.
7. Systematic Movement of Applicants for Medication.
8. Manner of Presenting a Plan to the Public.
9. Methods of Collecting Payment for Medical Care.
10. Collecting from the Low Income Group.
11. Method of Remunerating Physicians.
12. General Administrative Suggestions.
13. Uniform Universal Plan Impossible.
14. Good Plans Subject to Imitations.
15. Undesirable Type of Plan Establishes Dangerous Pattern.
16. Medical Profession to Control All Medical Affairs.
17. Freedom of Choice of Physician Is Essential.
18. Sliding Fee Scale.
19. True Voluntary Medical Charity.
20. Sudden and Drastic Changes Undesirable.

TEXTUAL DETAILS

The importance of the details of the report grows upon one as he studies the report, and returns to it to refresh his memory. It is full of concise items which are extremely practical, as is shown by the following quotations:

"It is usually better to expand existing plans than to start new ones."

"The size of the problem which a medical society intends to attack should be definitely determined."

"There has been a tendency to exaggerate the number of persons in the low income class for whom special provision is necessary."

"The old family doctor was a competent and friendly judge of the incomes of his patients, and of the satisfactory adjustments of payment."

"It is important that the field of the medical social worker should be clearly defined and separated from any part in the delivery of medical service."

"Insurance, taxation, budgeting, advance financing, and all other methods are nothing more than tools with which to conduct an economic transaction."

"The average charge to the persons receiving complete medical service including hospitalization for major illnesses is less per family than the majority of proposals for sickness insurance would impose on all families, sick or well."

A physician must read the report again and again in order to grasp its full value.

THE CONGRESSIONAL BILL FOR SOCIAL INSURANCE

The January issue of the *Bulletin of the American Medical Association* contained an outline of the provisions of the Social Insurance Bill introduced in the United States Senate by Senator Wagner of New York State. This outline was reproduced in *The Journal* of The Medical Society of New Jersey, February, 1935, page 106, for it reflected the attitude of the National Administration in regard to economic security.

The Wagner Bill presumably is an Administration measure (Senate 1130), but it was apparently dropped, for the House of Representatives Bill 7260 is a similar measure which the House passed, and the Senate also passed after making many minor amendments. The Bill is now in conference and will probably be enacted into law in the near future.

The New Jersey Journal of November, 1934, page 651, carried an account of the establishment of a *Federal Committee on Economic Security*, and an announcement of a three-day meeting of an *Advisory Council* to the committee, on which the Medical Profession is represented.

The description of the Wagner Bill published on page 106 of this Journal for February will apply in a general way to the Bill which is now in conference.

COUNTY SOCIETY REPORTS

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The members of the *Cumberland County Medical Society* were the guests of Dr. Reba Lloyd on the afternoon of Tuesday, July 9th, at Ivy Manor, Jericho, the county branch of her sanatorium in Bridgeton. The President, Dr. S. B. Bennett, presided at the meeting, which was held on the spacious veranda. There was a large attendance of physicians from adjoining counties.

NEW MEMBERS

The following new members were elected:

Dr. Kenneth Corson, Vineland
Dr. Alfred E. Mezzetti, Vineland
Dr. Benjamin Berkowitz, Bridgeton

GROUP INSURANCE

An interesting presentation of the group insurance for health and accident, as contracted for by the State Medical Society, was made by Mr. Blankenstein, of Newark. He compared the cost of insurance at various ages; the difference between an insurance company registered in this State and one not, and the non-cancellable features of his company's policy.

E. R. A.

A report of the E. R. A. Committee indicated that there had been abuses of the medical agreement; and one doctor, after a thorough investigation, had been suspended from receiving E. R. A. fees for one month.

PUBLIC HEALTH HOUR

Dr. I. W. Knight, District State Health Officer, reported a gratifying increase in the number of children immunized against diphtheria and smallpox.

SCIENTIFIC

Dr. Francis Ashley Faught, Philadelphia, gave an address on "Low Blood Pressure and Its Significance". He was encouraging in his remarks, saying that low blood pressure does not cause death.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

EXECUTIVE COMMITTEE REPORT

A meeting of the Executive Committee was held on Monday evening, June 10, at the Fitkin Memorial Hospital, Neptune, N. J. The following men were present: Drs. Fairbanks, Fisher, Holters, Hunt, Prout and Featherston.

It was reported that sixty-seven members of the Society have signed the resolutions on hospital clinics. It is requested that returns be made to the Secretary as soon as possible, as it is necessary to have twelve more signatures before the resolutions can be adopted by the Economic Committee. (Journal, May, p. 336.)

VENEREAL CLINICS

The Secretary reported on a conference with Miss Evelyn T. Walker, Director of Public Health of the Monmouth County Organization for Social Service.

The first matter discussed was the formation of two venereal clinics in the northern and northwestern parts of the county. It was suggested that these clinics be maintained on the same basis as the pediatric clinics, and that they be directed by a committee from the Monmouth County Medical Society. The Social Service Organization is conducting an investigation and will report to the Medical Society at a later date.

OLD-AGE PENSIONS

The second matter discussed was the medical care for old folks receiving old-age pensions. It was reported that there are 800 in Monmouth County receiving this pension, and it is costing the county $200,000 a year. The maximum pension is $20.00 per person, and in this class there are two distinct groups. One group receives its entire aid from the State, and the other group is partially cared for by the County under the direction of the Welfare Board. Those receiving aid from the State are entitled to medical treatment under the Emergency Relief Administration, but those receiving aid from the County are not, and it is for this group that the Social Service Organization is endeavoring to provide the necessary medical care. It was felt that an arrangement similar to our Medical Agreement with the E. R. A. would be satisfactory.

WORKMEN'S COMPENSATION EXAMINATIONS

The following letter was sent to the Secretary by John J. Toohey, Jr., Commissioner of Labor of the State of New Jersey, and is quoted for the benefit of the Society:

"In connection with the administration of the Workmen's Compensation Bureau, I find difficulty in obtaining the coöperation of some members of the medical profession.

"On assuming office I promulgated a rule that no doctor shall make any medical examination of any person, in connection with a Workmen's Compensation hearing, on the premises of the Department of Labor, as the proper place for such examination is the private office of the doctor.

"To my surprise, I find that some doctors will frequently make a clandestine and hurried examination on the premises of the Bureau, and, in two cases that have come to my attention, in the men's toilet. Certainly such behavior does not add to the lustre of the medical profession.

"I would appreciate very much your kind dissemination of this rule among your membership, as inability to secure voluntary coöperation may impel me to sponsor drastic legislation to correct this condition."

FORMS FOR PHYSICIANS' LIEN LAW

The following is a résumé of the important points in the new Physicians' Lien Law of the State of New Jersey:

1. Every licensed physician shall have a lien for the reasonable charge for his or her services rendered in the treatment of any person who shall have sustained personal injuries in an accident and irrespective of the amount of such reasonable charges, all the said liens for services rendered to any one person as the result of any one accident shall not exceed twenty-five per centum (25%) of the amount of an award, verdict, report, decision, decree, judgment or settlement, this amount to be set aside until the completion of treatment.

2. Within ten days after the filing of such notice the physician shall send by registered mail a copy of such notice with a statement of the date of the filing thereof to the injured person and to the person or persons, firm or firms, corporation or corporations, alleged to be liable for damages for the injuries sustained by such injured person, if such name and address can be ascertained by reasonable diligence; and upon failure to send copies of the notices required by this section said lien shall be void.

3. Every county clerk shall, at the expense of the county, provide a suitable, well-bound book, to be called the physicians' lien docket, in which, upon the filing of any lien claim under the provisions of this act, he shall enter:

The name of the injured person, the date of the accident, the name of the physician making the claim, and, if stated in the lien claim, the name of the party or parties alleged to be responsible for said injuries.

And the said clerk shall make a proper index of the same in the name of the injured person; and such clerk shall be entitled to twenty-five cents ($.25) for filing each notice of lien, and twenty-five cents ($.25) for each search in his said office, said fee to include cost of search and certificate thereof.

4. Any person or persons, firm or firms, corporation or corporations alleged to be legally liable, or against whom a claim or lien shall be asserted, or their duly authorized representatives shall upon request, be furnished by any such physician within ten days of the receipt of such request with a statement of the injuries sustained by the injured person and an itemized statement of the charges and services rendered to date; and upon failure of the physician to comply with the provisions of this section, said lien shall be void.

A supply of the forms for filing liens may be had either at the Secretary's office or at the executive offices of the Fitkin Memorial Hospital and Monmouth Memorial Hospital.

COUNTY SOCIETY MEETING

The June meeting of the *Monmouth County Medical Society* was held in the auditorium of the Jersey Central Power and Light Company, Main Street, Allenhurst, New Jersey, on Wednesday evening, June 26, at 8:30 o'clock, Dr. W. H. Fairbanks presiding. Approximately thirty members were present, as well as some thirty guests,—members of the various first-aid squads and safety organizations who had received special invitations to this meeting.

The minutes of the previous meeting were read and approved and the report of the Executive Committee accepted.

NEW MEMBERS

The following men were elected to membership:

Dr. J. G. Feman, Keansburg, N. J.
Dr. Gregory E. Sacco, Red Bank, N. J.
Dr. Stanley Wilkins, Red Bank, N. J.
Dr. Ralph G. Woodruff, Englishtown, N. J.

SCIENTIFIC

The scientific program consisted of the following papers:

"The Splinting of Fractures at the Scene of Accident", by Dr. Robert H. Kennedy, New York, New York.

Dr. Kennedy described the Thomas leg splint and the Murray-Thomas arm splint, and the modes of applying these splints at the scene of accident. According to Dr. Kennedy, these splints are ideal in that they are cheap, of little bulk, and are adaptable to a large variety of fractures and patients of different size. They combine ease of application with efficiency in performing their tasks of securing alignment and providing immobilization. Dr. Kennedy's paper was illustrated by motion pictures.

"The Treatment of Fractures in General Practice", by Dr. O. R. Holters, Asbury Park, N. J.

Dr. Holters described the various common fractures seen in general practice, classifying them as those which could be treated by the general practitioner, and those which should be hospitalized under the care of the orthopedic surgeon.

HOSPITAL CONFERENCES

The clinical conference of the Fitkin Memorial Hospital was held June 11, 1935. The following program was presented:

Subacute Bacterial Endocarditis (case), Dr. Louis Albright.
Ulcerative Colitis (case), Dr. Harold Freedman.
Case of Unexplained Fever for Diagnosis, Dr. Harold Freedman.
Postmortem Findings in Leutic Heart Disease (case), Dr. Carlos Pons.

The following program was presented at the clinical conference of the Monmouth Memorial Hospital on June 19, 1935:

The Clinical Interpretation of Jaundice, Dr. Victor Knapp.
Cervical Cellulitis (case), Dr. Arthur Strauss.
Tumor of Third Ventricle of Brain (case), Dr. Morris Grossman.
Cerebellar Tumor (case), Dr. Morris Grossman.
Carcinoma Testicals (Bilateral) in Child Age 13, Dr. Byron Blaisdell.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The summer meeting of the *Warren County Medical Society* was held in the Elks Club, Phillipsburg, Tuesday, July 16th, at eleven o'clock. The meeting was called to order by the President, Dr. Herman Baldauf. Fifteen members were present, as follows: Drs. Paul Drake, Charles Lyons, Guernsey West, F. A. Shimer, of Phillipsburg; William Skinner, William Varney and J. M. Lemmon, of Washington; F. W. Curtis, of Stewartsville; James Weres, of Alpha; Frank Gordon, of Blairstown; G. W. Cummings and H. Bauldauf, of Belvidere; H. B. Bossard, of Harmony; Ralph Buchanan, of Warren Hospital, and J. J. Quiney, Roentgenologist, of Easton Hospital.

The minutes of the last meeting were read and approved. The application of Dr. Wallace R. Bostwick, of Blairstown, for membership was received and laid over until the next meeting.

A communication was read by the Secretary from the State Medical Society.

A report of the meeting of the Reporters and Secretaries meeting at Atlantic City was made by the Reporter and Secretary.

BULLETIN

A motion was adopted that our officers act as a committee to ascertain data about printing a bulletin and report at the next meeting.

SCIENTIFIC

Dr. J. J. Quiney, Roentgenologist, of Easton Hospital, Easton, Pa., then gave a very interesting paper on the development of peptic ulcer, showing slides of the lesions and their diagnoses. The paper was discussed by several members present.

The meeting adjourned to the dining room of the Elks Club for lunch.

1935 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

The Eighth Annual Graduate Fortnight of The New York Academy of Medicine will be held October 21 to November 2 and will be devoted to a consideration of *diseases of the respiratory tract.*

Eighteen important hospitals of the city will present coördinated afternoon clinics and clinical demonstrations. At the evening meetings prominent clinicians from various parts of the country, who are recognized authorities in their special lines of work, will discuss various aspects of the general subject.

A comprehensive exhibit of books and of anatomical, bacteriological and pathological specimens and research material will be assembled. Demonstrations will be held at regular intervals.

Speakers at the evening meetings will include Drs. J. Burns Amberson, George Blumer, Henry Chickering, Lloyd F. Craver, Alphonse R. Dochez, Leroy U. Gardner, Yandell Henderson, Charles J. Imperatori, Chevalier L. Jackson, Adrian Lambert, Howard Lilienthal, Harrison S. Martland, Jonathan C. Meakins, James Alex. Miller, Charles T. Porter, Maximilian A. Ramirez, Arnold R. Rich, David Riesman, Charles Hendee Smith and Harry Wessler.

The profession generally is invited to attend.

A complete program and registration blank may be obtained by addressing Dr. Frederick P. Reynolds, The New York Academy of Medicine, 2 East 103d Street, New York City.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1935

	Diphtheria Toxoid	*Smallpox Vaccine*
County	Month of July	Month of July
Atlantic	26	16
Bergen	40	62
Burlington	32	31
Camden	22	29
Cape May	48	52
Cumberland	139	111
Essex	359	285
Gloucester	15	20
Hudson	2	1
Hunterdon	0	5
Mercer	4	1
Middlesex	88	75
Monmouth	18	4
Morris	91	60
Ocean	2	6
Passaic	360	147
Salem	8	8
Somerset	49	77
Sussex	0	0
Union	130	151
Warren	86	37
Totals	1519	1178

OBITUARIES

FLOY McEWEN, M.D.

Dr. Floy McEwen was born on July 17, 1865, in New York City, attended grammar school there and the College of the City of New York from which he graduated and then entered the College of Physicians and Surgeons, Columbia University, graduating with the degree of M.D. in 1891. He began medical practice in Newark, N. J., and there continued actively till his death on June 11th, 1935.

He married Antoinette Currier in March, 1898, who survives him. His son, Dr. Currier McEwen, is Assistant Dean of New York University and Bellevue Hospital Medical College; and his daughter, Mrs. Edith McEwen Dorian, is a member of the teaching staff of the New Jersey College for Women.

Dr. McEwen was for years disabled by a painful and extensive multiple arthritis, but in spite of his disability he never lost his ardor for the interests of his life in medical practice and in diversions, of which the literature and celebration of Christmas was notable and occasioned his collecting a variety of items. His Christian religion was the secret of a fortitude under extreme disability and, at times, of very great pain.

A testimonial was given him by members of the Essex County Medical Society some years ago which testified to their appreciation of him personally and his loyal work as chairman of one of the active committees, that on Necrology.

His outstanding contribution to the work of the world was his loyalty to the cause of *certified milk* in maintaining, chiefly after Dr. Coit, the organization of the *Medical Milk Commission* of Essex County, the first in the world. This was founded by Dr. Coit who in 1892 originated that method of producing and delivering to the consumer initially pure milk. The death of Dr. Coit in 1917 closed the first era in this part of the world's medical history, the designing and bringing to fruition and maintenance this accepted standard of pure milk—the first in the world. Those who remember prior days of filthy milk uninspected for bacteria content, and the frequent epidemics of summer diarrheas which made the infant mortality so very high, will credit Dr. Coit for recognizing and designing a remedy. Dr. McEwen, long associated with him, has been an important factor in carrying on the organized work. It is universally admitted that *certified milk* has been the chief factor in raising grades of all milk sold for human food, with its important effect in saving untold numbers of infant lives. New Jersey and Essex County have reason to be recognized as having brought to the world in this movement of the past forty years benefits which are an honor and prestige to the medical profession.—Frank W. Pinneo, M.D

GEORGE B. PHILHOWER, M.D.

Dr. George B. Philhower, aged 72, civic leader and practicing physician in Nutley for nearly fifty years, died on May 23rd in St. Barnabas' Hospital, Newark, after a long illness.

Born in Croton, Hunterdon County, August 28, 1862, Dr. Philhower studied at Trenton Normal School and later received his M.D. degree at New York University. He served his interneship at Bellevue Hospital, New York, and opened his Nutley practice in 1886.

He served twenty-three years on the Board of Health, nine on the Board of Education, twenty-four on the Library Board and fifteen on the Park Commission. For twelve years he also was Town Physician. He was a member of the Essex County Medical Society.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING JUNE, 1935

Supplied by the State Department of Health

Name	Age	Date Death	Place of Death	Residence	Cause of Death
Henry Reiter	56	June 14	325 E. 25th St., Paterson	167th St., Bronx, N. Y.	Hypertensive heart disease Renal insufficiency.
Anne B. Newton	76	June 17	Orange Memorial Hosp., Orange	135 So. Or. Av., So. Orange	Aneurysm of aorta.
G. Floy McEwen	69	June 11	229 Broadway, Newark	Same	Pyelo nephritis.
Frank Kaufhold	51	June 17	41 Leslie St., Newark	Same	Coronary thrombosis.
Meyer Levin	37	June 19	Beth Israel Hosp., Newark	326 Avon Av., Newark	Carcinoma of stomach.
Edward J. McConaghy	53	June 18	Camden Co. General Hosp., Lakeland	203 E. Atlantic Av., Audubon	Lobar pneumonia.
Elias M. Duffield	60	June 27	55 State St., Glassboro	Same	Paresis. Uremia.
Harry W. Stout	44	June 29	Woodbury	Wenonah	Acute dilatation of hea



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OF

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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION

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FRANK OVERTON, M.D., Dr. P.H.

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EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

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EDITORIALS

The Social Security Act

The Federal *Social Security Act* is an accomplished fact. It became Law on August 14, 1935, but its far-reaching implications of governmental control cannot be predicted with accuracy. The broad principles of the Law are set forth in the summary that is printed on page 554 of this Journal.

The methods followed in the enactment of the Social Security Law recalls the feverish haste of 1917 in preparing for the participation of this country in the World War. Then a grave emergency was urged as the justification for untried experiments and wasteful expenditures. It cannot be said that an emergency now exists to justify experiments and expenditures which parallel those of war days. It is to be gravely feared that the new Law is only the beginning of an embarkation upon a scheme for the socialization of medicine with compulsory regimentation of all its services under leaders who have had no training or experience in the practice of medicine.

This Law deals with problems whose wise solution would constitute a great step toward the attainment of that freedom in whose name wars are waged.

It must be remembered that the World War did not change human nature, and that the very freedom for which the war was waged has resulted in despotisms greater than those for whose annihilation the war was prosecuted. The United States, the land of the free, is now dominated by a system of political despotism founded on emotion rather than reason.

The Medical Profession, represented by The Medical Society of New Jersey and the other States, and the American Medical Association, stands for freedom and for the orderly development of a system for promoting the health and the general welfare of the people. If legislation stops with the present Social Security Act, the plans for its administration may be developed in an orderly manner which will provide for the amelioration of many of the conditions which all physicians would like to see remedied.

The leadership of The Medical Society of New Jersey in calling a conference of the medical and allied professions and the welfare organizations, points the way to the solution of the major problems in both economic and scientific medicine in a manner which is both orderly and efficient.

Progress in the E. R. A. Project

The Medical Society of New Jersey took the initiative at the very beginning of the Emergency Relief Administration in offering a plan for the Medical Service Department of the State project. This plan has been preserved in its general form; and after two years of successful operation its main features have been adopted in several other states as the best plan that has been developed.

New Jersey's plan has proved its flexibility and its adaptability to the various conditions throughout the State. Experience has shown the ways in which the system can be improved and extended, along the lines of a natural evolution.

The formal agreement between The Medical Society of New Jersey and the State Council of the Emergency Relief Administration expired on the last day of August; but a new agreement has been consummated and is now in operation as described on page 548.

The Psychology of Unemployment

Many colleges have sought to interest unemployed workmen in extension courses, but with unsatisfactory results. The employed workmen maintained the same grades and made the same progress as the average full-time student, but the majority of those classed as unemployed made poor progress and maintained much lower grades than the employed.

The cause of the mental inertia of the unemployed is often ascribed to the mental depression and the worry that goes with a lack of the opportunity to make a prosperous living. The theory is that if those without work were employed, they would be relieved of the worry that deadens their minds, and would devote their spare energies to studies along cultural and scientific lines.

Experience has shown that mental apathy is the *cause,* rather than the *result,* of unemployment. Over two million persons in the United States were voluntarily unemployed during the height of prosperity; but they had to do some work or starve, for in those days there was no dole offered as the prize for idleness.

If a man will not do physical work for wages, he will not exercise his mind in educational lines.

Typhoid Carriers

The menace of typhoid fever has been almost completely removed by effective sanitary control of environmental conditions and the observation of personal cleanliness. Yet there still remains the menace of the chronic carriers. These are few in number, and are usually in good health. Their coöperation is often difficult to get, for the evidence of the carrier condition is almost always supplied by a State laboratory whose findings the carriers do not or will not understand. A typhoid carrier is one of the most difficult of all the problems which a health officer encounters, especially in a country district where everybody knows his neighbor and information travels with incredible speed.

Carriers harbor the typhoid bacilli in their intestines, their urinary bladder, and especially in their gall-bladder. It has been the custom of health officers to advise operations on the gall-bladder for the cure of the carrier condition, but comparatively few of the cases have come to operation, and the results have not been convincingly sure.

The July fifteenth issue of "Health News", the weekly publication of the New York State Department of Health, contains a report of operations that have been performed during the last fifteen years on ninety-one persons who were listed as chronic typhoid carriers by the Department. In eleven, drainage was done, and in eighty, the gall-bladder was removed.

In fifty-six of the cases typhoid bacilli were found present in the gall-bladder. Thirty-six of the cases were followed up carefully, and twenty-seven were found to be free from typhoid bacilli after repeated examinations of the intestinal contents.

These figures are encouraging, for they show the elimination of the bacilli in seventy-five per cent of those in whom the gall-bladder has been proved to harbor the bacilli.

The most reliable diagnostic procedure in determining the gall-bladder to be the site of the bacilli is that of securing a specimen of the duodenal contents by means of a duodenal tube; but even that may not be confirmative unless the specimen contains bile,—which is not always present in the duodenum.

Nothing is more difficult than to persuade the suspected carrier to submit to repeated duodenal examinations. The advice and support of the family doctor is essential in obtaining the specimens, and maintaining the confidence of the carrier that no publicity will be made of his condition so long as he observes the rules prescribed by the health officer. It is fortunate that typhoid is now such a rare disease that very few new carriers will develop; and the number will therefore dwindle to the vanishing point with the passing of the present generation. But this fact does not relieve either the health officer or the family physician of responsibility for the supervision of the cases, about fifty in number, which are known to be typhoid carriers in New Jersey.

E Pluribus Unum

The fate of private medical practice now lies in the hands of the individual members of the State and County Medical Societies.

Teamwork—that's the thing that wins. Organization, unity of purpose, willingness to give and take for the team, leadership and *prompt action,* produce results.

This thought is expressed admirably in the words of the poem, "It ain't the Commander General nor the Army as a whole, but the everlastin' teamwork of every bloomin' soul."

More than half of the time and energy, thought and effort given by the elected and appointed leaders in our State and County Medical Societies is wasted through "lost motion" in the County Society "machinery" which gets the plan to the individual member and stirs him into action.—L. A. W.

County Society Reports

The season for County Medical Society meetings opens on September 10, when Bergen and Sussex Counties meet. The series will close next July with the Hunterdon meeting on the twenty-first. Between those two dates, 143 meetings of the County Medical Societies are scheduled; and in addition, Monmouth and Morris counties hold clinical meetings several times a year.

REPORTING MEETINGS

Every meeting of a County Medical Society is worthy of reporting space in The Journal, for three reasons:

1. It shows the response of the Society to the state-wide projects of The Medical Society of New Jersey.

2. It sets forth the original projects of the Society for the benefit of the other societies.

3. It describes the post-graduate work of the Society, and gives credit to those who prepare scientific addresses and demonstrations for the benefit of practicing physicians and the people generally.

During the season September, 1934, to July, 1935, 141 meetings of County Medical Societies were held, of which 110 were reported in this Journal, or 77.5 per cent of the total number held. The list of those reported included all those of the larger societies; but this fact should not be taken to justify the exclusion of the smaller societies from reporting. The Journal has printed every report that has been received regardless of the form in which it was

written. The main point has been to get the material,—the Editor will put it in form for printing.

The reports of the County Society meetings held during the season filled ninety pages of The Journal,—an average of eight-tenths of a page for each meeting. This was one-seventh of the total number of pages in The Journal during the period of the reports.

SCIENTIFIC PAPERS

Special efforts have been made to secure the scientific papers read before the County Societies and to publish them in The Journal. These papers are of two types:

First are the papers which report original work, especially summaries of the studies of cases in local hospitals. These papers have been published in full in The Journal. A small society or hospital can produce a series of as good quality as a large society.

Second are papers which are of the text-book style, and summarize the modern knowledge of a subject. These are largely indexes of the subjects, and are usually printed in abstract. They are invaluable to the general practitioner as a guide to what he shall consider in his examinations and treatments. The law protects him if he follows the procedure suggested in these abstracts.

The abstracts and descriptions of the scientific papers are not printed on the pages of the department of County Society reports. If they are to be reported at all, they are placed in the department of scientific medicine. The department of County Society meetings is set aside for reports of society administration and projects.

THE REPORTERS

The high grade of the work of the reporters of the County Societies deserves recognition. They have utilized the opportunities offered by the expansion of the administrative work of the County Societies, and have made their reports increasingly full and interesting.

Then too, the amplified descriptions sent in by the reporters has had a reflex action in encouraging the members to greater activity.

We look forward to a great expansion of the Journal's department of County Societies in keeping with the progress in other lines of medical activity.

Projects of the Woman's Auxiliary

The Journals of the several *State Medical Societies* are devoting more and more space to the activities of the Woman's Auxiliaries and their opportunities to promote and support the projects of the medical profession. The articles are usually general in their scope and give the impression that the Auxiliary members are expected to initiate *independent studies* of public health problems, and to teach the laity regarding the health activities of their husbands.

The very multiplicity of the projects of the Auxiliaries defeat their own objectives. Many of the projects sponsored by the Auxiliary are not those in which the Medical Societies are taking the leadership and initiative.

The Auxiliary is designed to assist the Medical Societies in carrying out the projects which are originated and promoted by the physicians. Its own peculiar field is to *assist* the medical societies in carrying out their projects, especially those whose success depends upon the education of the people.

The Medical Society of New Jersey has promoted the activity of the *Speakers' Bureau,* in which the Auxiliary is a *liaison group* between the Medical Societies and the Public Health Organizations.

Physicians realize the need of engaging in *public health education;* but they hesitate to enter the field because of the lack of an organized system for making contacts with the lay health groups. The Auxiliary is the natural group to make the contacts.

Specifically, the members of the Auxiliary are urged to make the arrangements for supplying speakers to any lay organization which is promoting a meeting to discuss a public health project.

The Parent-Teachers Association is typical of an active group which promotes public health meetings. The local Medical Society is the natural group to whom the associations should turn for speakers to discuss local health projects.

Custom rather than ethics prevents physicians from *offering* their services as speakers to the lay groups; but doctors will speak to the groups if they are invited to do so. The members of the Auxiliary are the natural group to make the arrangements for local physicians to address the lay groups.

Doctors' wives are active in social lines and are members of the lay health organizations. They are in a unique position of being able to secure the consent of the physicians to address a lay group, provided the doctors are invited by the group to give an address on a particular subject in which the group is interested.

It is not sufficient that an Auxiliary shall stand ready to carry out the directions of a Medical Society. The opportunity of the members of the Auxiliary consists in their *initiative to propose* to a lay group that it invite a physician to give an address at its meeting. There is no doubt regarding the compliance of the physicians with a request from a lay group.

The Speakers' Bureau fills a real need in carrying out a public health project sponsored by a medical society, such as the Public Health Hour of The Medical Society of New Jersey.

Integration of the Medical Profession

The Trustees of the American Medical Association in their Annual Report suggested that the House of Delegates develop a policy in regard to the *integration* of the medical profession. The House responded by adopting a recommendation that the Officers and Bureaus of the A. M. A. study the subject carefully and formulate a policy to be presented to the meeting of the House of Delegates in 1936.

The word *integration* means a bringing together of parts into a complete whole. Integration of the medical profession implies not only unity in policy, but also the acceptance of official power and responsibility for licensing and disciplining all physicians. It would impose upon the medical profession not only its present responsibility of setting up standards of professional education and conduct, but also that of enforcing those standards.

Specifically the plan of integration would endow The Medical Society of New Jersey with the legislative, executive and judicial powers which are now vested in the Board of Medical Examiners of New Jersey, and the Department of Education and the Grievance Committee of New York State. It would also impose on the State Society some of the prerogatives and duties of the medical schools.

Integration has been seriously considered in at least two states and has been adopted for the dental profession by the State of Oklahoma, but information regarding it is meager. The only reference to the subject in the Journal of the A. M. A. during the past year is that to the action of the House of Delegates recorded in the Journal of June 29, 1935, pages 2354, 2357 and 2368.

One frequently hears physicians make the vague suggestion, usually with some impatience, that doctors should control all matters relating to the practice of medicine. The lessons of history are opposed to such an assumption of power and responsibility by the medical profession.

Human relations involve two principles:

1. The adoption of *standards* of belief and conduct.

2. The *enforcement* of compliance to those standards by not only the professional leaders, but also by the *people*.

The modern Church has gone through a trial of the principles of integration over a period of thousands of years, beginning with *theocracy*, passing through the stage of *established churches*, and ending with *religious freedom*, or absence of integration.

The official medical societies of the several states have passed through an evolution of the principle of integration of which the experience of New Jersey Society, the oldest in the

United States, is typical. Founded on July 23, 1766, the Society at once exerted a powerful influence on medical legislation. At first its advice was recognized by the judges who had the power of issuing licenses admitting physicians to practice. The law of June 2, 1790,—the first charter of the Medical Society,—granted it "full power and authority * * * to make such laws, ordinances, and constitutions for the well ordering and governing of said Society or which shall have any tendency to promote the benevolent object and principles of the institution, and which shall be obligatory on the members thereof, and the same to alter, diminish, and reform as to them shall seem necessary and convenient". (Transactions 1766-1858, page 89.)

This act was superseded by another law passed on February 16, 1816, authorizing the formation of County Societies, on whom was imposed the duty of examining and licensing candidates to practice medicine.

Previous to 1816, the *preceptorial* system of medical education was recognized, consisting in the apprenticeship of a medical student to a practicing physician who undertook to teach him during four years at a fee of one hundred pounds. (Transactions May 5, 1767, page 18.) After his apprenticeship, the candidate came up for an examination by a committee of the Medical Society; and if found worthy, he was admitted as a member of the State Society and was given the legal right to practice medicine.

The teaching prerogative of the Medical Society was recognized by the word "faculty", which first appeared in the Transactions of November 7, 1769. The Medical Society of the State of Maryland is still called officially "The Medical and Chirurgical Faculty of Maryland".

The rise of medical schools led to their recognition by the Law passed January 28, 1830, by which students receiving the degree of Doctor of Medicine were permitted to register as legal practitioners of medicine without further examination. But the medical societies continued to exercise their teaching and licensing prerogatives until the enactment of the present charter of the State Society on March 14, 1864, which took effect on the fourth Tuesday of January, 1866,—almost exactly a century after the foundation of the State Society. This act recognized the validity of medical degrees granted by Medical Colleges, and was supported by the medical profession because of the great difficulty of enforcing their own educational standards.

The appendix to the Transactions of 1766-1858 contains the names of 372 physicians who were licensed by The Medical Society of New Jersey betweeen the years 1816 and 1843; but the preceptorial system continued until the early nineties.

The Medical Society also had the power of disciplining members, but on November 11, 1823, it seriously discussed the question of asking the Legislature to establish a legal method of discipline. (Transactions, page 223.) The evolution of this idea resulted in the establishment of the present State Board of Medical Examiners in 1890.

This brief review of the history of medical societies illustrates the trend of the control of medical practice away from integration.

The great objection to integration is that the control of practice is a *public function* to be exercise by public officials for the benefit of the people. To impose that duty upon the medical profession would prove an intolerable burden from which our predecessors were glad to escape.

The function of the Medical Societies is to establish *standards of practice*. The enforcement of these standards properly belongs to government officials, as in the present system which was evolved through a century of experience. The Medical and Allied Professions of New Jersey have demonstrated their ability to guide medical legislation wisely and efficiently under the present system.

ILLNESS OF PRESIDENT NEWCOMB

Dr. Marcus W. Newcomb, President of The Medical Society of New Jersey, was suddenly taken ill with acute appendicitis on Thursday, August 29. The next day an operation was performed in the Burlington County Hospital, Mt. Holly, by Dr. T. J. Summey. It is reported that Dr. Newcomb is resting comfortably. The members of the Medical Society send him their greetings and best wishes.

ORIGINAL ARTICLES

ABNORMALITIES OF THE ALIMENTARY TRACT AMONG 15,968 NEW-BORN INFANTS, WITH ROENTGENOLOGICAL EVIDENCE

By Benjamin M. Joseph, M.D., Jersey City, N. J.

From the Services of the Margaret Hague Maternity Hospital, Jersey City, N. J., from October, 1931, to February 1, 1935. Read before the Section on Pediatrics at the 169th Annual Meeting of The Medical Society of New Jersey, May 2, 1935

This paper constitutes all the recorded cases of abnormalities of the alimentary tract occurring in 15,968 new-born infants delivered at the Margaret Hague Maternity Hospital. This list comprises twenty-one cases, as follows:

Complete atresia of the esophagus, two cases;

Cardiospasm in one case;

Pylorospasm, four cases;

Pyloric stenosis, three cases;

Obstruction in the duodenum, one case;

Obstruction of the ileum, two cases;

Obstruction at the ileo-cecal valve, one case;

Obstruction at the splenic flexure in one case;

Imperforate anus, two cases;

Diaphragmatic hernia, two cases;

Umbilical hernia with complete eviseration, one case;

Strangulated hernia, one case.

CONGENITAL ATRESIA OF THE ESOPHAGUS

Atresia may be defined as a congenital absence or a pathological closure of a normal opening or passage.

Congenital atresia of the esophagus may occur in several forms. The simple atresia, not communicating with the trachea, may occur just above the diaphragm or below the bifurcation of the trachea. The upper portion may end in a cul-de-sac about six centimeters below the level of the glottis. This condition is compatible with life. It is due to failure of development of the tracheosophageal septum and canalization. There is great tendency in these cases toward hemorrhage.[1] Gastrostomy may prolong life.[2]

In the communicating types, the upper sac may communicate with the trachea, the lower sac may communicate with the trachea, or both sacs may communicate with trachea. The commonest type is a blind upper sac, and a communicating lower sac.[3] The theory of external pressure of aberrent vessels causing these anomalies is strongly supported by A. Keith[4] and Jacobi and Rascoff.[5] X-ray interpretation of atresia is very simple. Aspiration pneumonia nearly always accompanies the communicating types.

Baby Girl G———

One of twins. Normal delivery. Respiration delayed. Put in Drinker apparatus and given oxygen. Three hours after delivery, child became very cyanotic. Seven hours after delivery, baby fed and regurgitated immediately after. All feedings subsequently were regurgitated.

Radiograph four days after birth revealed an atresia of the esophagus at the level of the upper sternum.

Gastrostomy was performed on the fifth day and the child expired ten hours later.

Autopsy revealed a congenital stenosis of the esophagus, a tracheosophageal fistula and an extensive bilateral broncho-pneumonia.

Baby Boy A———

Normal delivery. No abnormalities noted at the time. Shortly after birth the infant became very cyanotic and had a weak cry. Fed three hours after birth with immediate expulsion of food through the nostrils. Subsequent feedings caused extreme cyanosis relieved when expulsion of food was complete.

Diagnosis of obstruction of the esophagus was made on the second day after delivery.

Radiograph showed a complete atresia of the esophagus at the level of the third rib. Surgical intervention considered inadvisable. Death occurred on the eighteenth day.

CARDIOSPASM

Cardiospasm is a recurrent dysphagia due to a spasm or non-relaxation of the lower end of the esophagus and usually leads to dilatation.

Cardiospasms are more likely to develop during the second six months of life. X-ray

usually reveals a very narrow terminal end of the esophagus as it enters the stomach, associated with a dilatation above the spasm.

Baby Boy M———

Normal delivery. Vomiting noted on the second day, the vomiting occurring about two minutes after a feeding. Atropine given to relieve the vomiting. A barium meal was given on the fifth day, at which time a definite cardiospasm with a dilatation of the esophagus was noted. Subsequent course with the administration of atropine and clysis was good. The infant was discharged on the 55th day. Birth weight 2180 grams. Discharge weight 3260 grams.

PYLORIC SPASM

Pyloric spasm has been ascribed to improper food, vagatonia, hyperadrenalism, hyperacidity, and hyperaesthesia of the mucous membrane. It may start at any time during the neonatal period. Generally, however, the symptoms occur later than those of pyloric hypertrophy. It is most common in boys in the first year of life and may recur. The absence of a palpable, hard, pyloric tumor is very important in the diagnosis, as also is the presence of bile in the vomitus.

Roentgenological studies of the normal gastro-intestinal tracts in new-born infants reveal the following:

1. The shape of the stomach is not constant, varying in different individuals and in the same individual.

2. The size of the stomach varies among individuals and in the same individual.

3. The position of the stomach may vary from the vertical type to the horizontal type.

4. The emptying time of the infants' stomachs varies from two to eight hours.[6] The majority of workers, however, feel that the normal emptying times should be within five hours. Prolonged emptying time does not necessarily indicate an abnormality, especially if unaccompanied by signs or symptoms.

5. A good portion of the meal reaches the ileum in five hours.

6. Visualization of the cecum at eight hours is normal, the hepatic flexure of the colon at twelve hours and the colon empty at the end of twenty-four hours.

Baby Boy S———

Normal delivery. No abnormalities noted. Two days after birth the infant began vomiting at frequent intervals and lost considerable amount of weight. Atropine was attempted in order to control the vomiting; and on the sixth day an x-ray series was taken of the gastro-intestinal tract, at which time the radiographs revealed a marked retention of barium at the end of five hours and a 10 per cent residue in the stomach at the end of twenty-four hours.

The patient continued to lose weight and it was necessary to give clysis and various formulae.

A surgical consultation advised against operation. A transfusion of 40 c.c. whole blood was given.

On the following day a duodenal tube was passed to the stomach and allowed to remain for eight days. By the 31st day the infant had lost 1000 grams, and from then on there was a slow steady gain up to the time of discharge, which was on the 90th day.

Birth weight 3900 grams. Discharge weight 3800 grams.

Baby Girl B———

Normal delivery. Birth weight 3000 grams. Vomiting began ten hours after birth. Clysis given to sustain life and atropine given to check vomiting. A gastro-intestinal series was done on the eighth day at which time was found that one-third of the meal remained in the stomach at the end of twenty-four hours. *Conclusion*: An obstruction to the pylorus, possibly spastic. Clysis and atropine continued for four days.

The child began to gain weight. Vomiting became less frequent. Discharged on the 29th day. Discharge weight 3150 grams. Atropine therapy continued after her discharge from the hospital.

PYLORUS SPASM

Baby Boy E———

Normal delivery. Immediately after delivery, the general condition became quite poor. Oxygen and maternal blood were given. Infant started vomiting all his feedings. Atropine was given. Loss of weight was moderate; and on the eighth day an x-ray series was done, at which time a fair amount of barium was found in the stomach at the end of five hours.

Impression: Pylorus spasm. Vomiting ceased. There was a gradual increase in weight to the nineteenth day, at which time the infant was discharged. Birth weight 2500 grams. Discharge weight 2500 grams.

Baby Boy H———

Normal delivery. Twenty-four hours after delivery the child began to vomit. Atropine was given. Clyses were instituted to check the rapid loss of weight. A gastro-intestinal series was done on the eleventh day; and at the end of twenty-fours hours, approximately one-sixth of the barium was still in the stomach. Vomiting continued at irregular intervals, but after the fourteenth day there appeared to be a steady gain in weight. Subsequent course was good. Discharged on the sixtieth day.

Birth weight 3350 grams. Discharge weight 4500 grams.

CONGENITAL HYPERTROPHIC PYLORUS STENOSIS

This condition affects all classes. It is as frequent in breast-fed as in bottle-fed babies. It occurs most often in the first born and in the male infant. Anatomically the pars pylorica is represented by a dense, hard, cylindrical or sausage-shaped tumor three-fourths of an inch long, with a small or occluded lumen which admits the passage of a probe. The mucous membrane is thrown into folds which occlude the canal. On section, the tumor is due to a thick, hard, dense, circular muscular coat. There is no fibrosis, and little or no hypertrophy of the longitudinal muscle. F. J. Poynton,[7] in his series of one hundred consecutive cases, palpated a tumor mass in every case.

Vomiting began during the first week in 19 per cent, the second week in 23 per cent, and in the third week in 22 per cent. X-ray diagnosis depends upon the failure of the barium meal to leave the stomach in appreciable amounts after hours have elapsed.

Baby Boy K———

Normal delivery. Condition good. Put to breast seven hours later, after which it vomited. Unable to retain subsequent feedings. Infant continued to lose weight rapidly. Numerous formulae and clysis attempted.

Radiograph of the gastro-intestinal tract on the sixth day revealed an obstruction at the pyloric end of the stomach. Death occurred on the eighth day.

Post mortem examination revealed a congenital atelectasis with massive hemorrhages, wide ductus arteriosis, multiple hemorrhages of the serous membranes, stomach, and meninges; acute gastro-enteritis, hypertrophy of the pylorus, dilatation of the stomach; and laceration of the tentorium.

Baby Boy M———

Normal delivery. Birth weight 3900 grams. Left the hospital on the eighth day with a discharge weight of 3530 grams. Three days later the child was admitted to the hospital because of vomiting. Peristaltic waves were seen over the abdomen.

On the thirteenth day in the hospital (its twenty-first day of life) a gastro-intestinal series was requested and an x-ray report revealed a retention of barium meal within the stomach at the end of seven hours. Transfusions were given on the fifteenth and thirty-fifth days.

On the forty-sixth day surgical consultation decided upon an operation. The child was given clyses and a transfusion prior to operation. A tumor mass of cartilaginous consistency two centimeters long was found.

Subsequent course was uneventful. All feedings thereafter were retained. Discharged on the eighty-eighth day. Weight on discharge 3860 grams, 560 grams above its readmission weight.

Baby Boy K———

Normal delivery. Apparently normal infant. Weight 3970 grams. Absolutely no complaints during its stay of ten days at the hospital. Discharge weight 3750 grams.

Four days later, the infant began vomiting after every feeding. The infant was readmitted to the hospital for observation on its twenty-fifth day. Diagnosis of pyloric obstruction was made, and the infant was operated upon on the twenty-ninth day. The pylorus was found to be hard and firm and the size of a large almond. Subsequent course was good. The child was discharged in excellent condition eleven days after operation.

OBSTRUCTION AT THE DUODENUM

Little mention is made of obstruction at the duodenum caused by bands or adhesions. These adhesions may be the result of a fetal peritonitis,[16] of a band adherent to the gall-bladder, or of compression by mesenteric vessels. Obstruction at the duodenum has been reported by Ladd[15] and others. Frequently it is very difficult to differentiate from pyloric stenosis. The presence or absence of bile in the vomitus is an important point in the differential diagnosis. X-rays are conclusive, and may indicate the extent of the stenosis and the level of the atresia.[17]

Baby Boy D———

Apparently normal delivery, with projectile vomiting immediately following birth, attended with marked loss of weight. A gastro-intestinal series was done on the fourth day, at which time was noted a marked retention of the barium meal in the stomach at the end of six hours. Conclusion, obstruction at the pylorus.

The infant was operated upon the seventh day. A large single adhesion band surrounding the distal portion of the first part of the duodenum was found. This band was broken. The subsequent loss of weight was moderate. The vomiting became less severe; and after the thirteenth day the infant retained most of its feedings. The child was discharged on its thirty-third day. Birth weight 3000 grams. Operative weight 2380 grams. Discharge weight 2900 grams.

OBSTRUCTION AT THE SMALL AND LARGE INTESTINE

The most frequent site for obstruction is the ileum and cecum. It appears less frequently in the duodenum and jejunum, and at least frequent in the colon. In this series there are three cases of obstruction in the ileum and

cecum; one case of obstruction at the duodenum; and one case at splenic flexure of the colon.

In all cases the proximal portion of the gut was markedly distended. In three cases of the five of this group, obstruction was caused by bands of adhesions. One case was due to volvulus and a kink in the ileum.

In the fifth case the family refused operation. Sidney Farber[8] describes a simple procedure for diagnosing congenital atresia of the oesophagus or intestine by means of microscopic examination of the meconium. He states that in normal meconium, cornified epitheleal cells are constantly present. These cells are derived from the skin of the fetus which are swallowed with other amniotic sac contents. The absence of cornified cells is, therefore, proof of congenital atresia.

X-ray interpretation—Roentgenograms are indispensable for early diagnosis. A step ladder appearance and fluid levels show a well advanced obstruction.

Baby Girl K———

Born at home. No abnormalities noted. On the second day the infant began to vomit, and the abdomen became markedly distended. Peristaltic waves were noted at this time. The infant expired on the following day.

Autopsy report: Acute fibrino-purulent peritonitis; perforation of rectum and cecum; mesenterium commune with possibility of volvulus; acute gangrene of the cecum; congenital kink and diverticulum of the ileum.

Birth weight 3600 grams. Weight before expiration. 3240 grams.

OBSTRUCTION AT THE ILEUM

Baby Girl C———

Normal delivery. No abnormalities noted at birth. On the first day following birth, the abdomen became markedly distended, and vomiting started simultaneously. The child continued to lose weight rapidly.

A gastro-intestinal series was done on the ninth day. The stomach emptied itself slowly, but was entirely empty in twenty-four hours. A fluid level, however, increased in amount in the lower portion of the abdomen. The weight loss was marked. A transfusion and clyses were given.

On the twelfth day an enterostomy was performed. There was a tremendously dilated portion of intestine between a band of adhesions at the terminal ileum; and the band of adhesions directly proximal to the descending colon at which point an appendix was present.

The adhesions were broken and a catheter was inserted into the dilated portion of the intestine. The condition improved for a while during which time the weight started to rise. The abdomen again became distended and fecal vomiting developed on the fiftieth day, the thirty-eighth post-operative day. On the same day the ileum was resected. Transfusion was given at this time. The infant gradually lost weight and strength, and expired on the eighty-second day.

OBSTRUCTION AT ILIO CECAL VALVE

Baby Girl C———

Normal delivery. On the following day the infant vomited after every feeding. Atropine was given by mouth. On the seventh day the abdomen became quite distended, and showed definite peristaltic waves. Rectal examination revealed an obstruction.

On the eighth day a barium enema was given which revealed a spastic, though patent, large intestine. On the ninth day the infant developed fecal vomiting. The family refused operation. On the fourteenth day a gastro-intestinal series was done, and at the end of twenty-four hours none of the barium meal had entered the large intestine.

Diagnosis was made of obstruction at the ilio-cecal valve. Child died on its twentieth day.

OBSTRUCTION AT THE SPLENIC FLEXURE

Baby Boy W———

Normal delivery. Birth weight 2250 grams. Infant slightly cyanotic at birth. On the seventh day the infant began to nurse poorly; the twelfth day he developed impetigo; and on the sixteenth day there appeared a sudden ballooning of the abdomen. The following day the condition of the infant became markedly worse and a surgical consultation was sought, but the infant expired a few hours later.

Autopsy report: Intestinal obstruction at splenic flexure due to congenital adhesions.

IMPERFORATE ANUS

The anus and the anal canal are formed from practodaeum by the absorption of the cloaca. Malformations are due to imperfect absorption. A membrane may close the orifice; or a thick fold of skin may extend from the median raphé of the scrotum over the anal orifice to the tip of the cocyx.

Baby Boy D———

Breech extraction. Imperforate anus was noted one hour after birth. A needle was inserted through the skin covering the anus, and a small amount of meconium obtained. The infant was operated upon nine hours after birth, at which time a skin incision was made and a rubber tube drain inserted into the rectum. The infant was discharged on the tenth day in excellent condition.

Baby Boy B———

Normal delivery. Twelve hours after birth, imperforate anus was noted. The infant was operated

upon twenty-three hours after birth, at which time a probe was inserted into a very small opening. An incision was made along the probe, and the skin was resected until the anal opening admitted a finger. A normal stool was passed the following day. The child was discharged from the hospital on its eleventh day in excellent condition.

CONGENITAL UMBILICAL HERNIA

Congenital hernia is relatively rare, occurring about once in five thousand to six thousand births. It is apparently more common in males.[14] It is to be differentiated from the rare and more extensive defect of the abdominal wall that results in abdominal evisceration. This latter type is truly not a hernia, because there is not a true umbilical ring. In this case we have a combination of the two. Cases of evisceration are very often associated with anencephaly.

Baby Boy P———

Breech extraction following placenta previa. The infant was premature and stillborn.

Autopsy: There was found a complete separation of the mid-line of the abdomen; through this opening there presented an umbilical hernia, the walls of which were the cord. The hernia contained all the abdominal viscera including the liver and the spleen. The diaphragm was also incomplete, and a portion of the lung extended into the hernia. There was no anus present. Weight 1750 grams.

STRANGULATED HERNIA

Strangulated hernia is fairly frequent and usually occurs in a previously reducible hernia. A continued state of an irreducible hernia results in strangulation. Strangulation is not common, but occasionally occurs in infants three to six weeks old in whom hernia has appeared suddenly and for the first time.

Classical signs and symptoms are: A swollen, irreducible, tender mass accompanied by vomiting with no passage of flatus nor feces. Infants cry continuously and refuse to eat.

Baby Boy M———

Normal delivery. Baby did well for a week, at the end of which time he developed impetigo. On the fourteenth day a swelling was noted in the scrotum. During the preceding twenty-four hours it had refused one feeding, had vomiting one feeding and became unusually drowsy. Vomiting continued for the next twenty-four hours, after which time a diagnosis of strangulated hernia was made.

Operation was performed on the fifteenth day. Immediately after the operation, the infant developed a temperature which lasted three days. Feedings became regular, and the infant was discharged twenty days after operation in excellent condition.

DIAPHRAGMATIC HERNIA

J. Basil Hume[10] defines diaphragmatic hernia as a protusion of some of the abdominal contents through a congenital defect in the diaphragm.

There are three types of diaphragmatic hernia:

1. Hernia through the peritoneal membrane.
2. Hernia through the dome.
3. Hernia through the esophageal orifice.

Carl Hedbloom[11] reported that one-third of all diaphragmatic hernias are congenital. Philemon E. Truesdale[12] stresses the complexity and variety of symptoms due to diaphragmatic hernia. In infants, cyanosis is always present. The physical signs found are dependent upon the amount of hollow abdominal viscera in the pleural cavity. The affected side of the chest is usually prominent, and is restricted in motion. Litten's sign is absent. Dextrocardia is always present to some degree in hernia on the left side. The roentgenogram is most important. There are isolated cases in which infants have been successfully operated upon for congenital diaphragmatic hernia.[13]

Baby Girl T———

Immediately after delivery, respiration was sluggish, and cry was very weak. Put in Drinker apparatus. Immediate reaction good. One hur after delivery, infant became extremely cyanotic. Death occurred six hours later.

X-ray revealed the entire left thoracic cavity filled with intestines, indicating the presence of diaphragmatic hernia.

Baby Girl S———

Premature and stillborn. Autopsy report: Weight 2910 grams. There was no diaphragm found on the left side. The heart was completely displaced into the right chest. The left lung was compressed and flattened against the mediastinum. The left chest contained the transverse colon, ascending colon, a portion of the ileum, the stomach, pancreas and spleen, and the left lobe of the liver.

COMMENT

It is to be remembered that the roentgenograms are exceedingly important in the diagnosis of abnormalities of the gastro-intestinal tract only when they are considered along with the clinical evidence. They should be used to

corroborate or to confirm the diagnosis. I firmly believe they should be employed in cases of persistent vomiting and be employed early. They should also be taken in cases of prolonged abdominal distention.

In conclusion, permit me to stress the importance of differentiating the curable from the incurable types; and the operative cases from the nonoperative cases. The clinical pictures of the curable and incurable types,—the operative and non-operative cases,—are similar and confusing. A thorough knowledge of all conditions mentioned, therefore, is necessary. Good facilities should be available for differential diagnosis to determine the prognosis and treatment.

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THE INFLUENCE OF BONE STRUCTURE ON PURULENT LESIONS OF THE TEMPORAL BONE

By Samuel J. Kopetzky, M.D., F.A.C.S.,
Professor of Otology, New York Polyclinic Medical School and Hospital

Read before the Section on Eye, Ear, Nose and Throat at the 169th Annual Meeting of The Medical Society of New Jersey on May 1, 1935, in Atlantic City

In selecting a topic for presentation, I am mindful of the fact that my audience is composed of practicing otologists, and that I must bring you something which is capable of translation into action at the bedside.

In the older literature, the conception prevailed that an otitis which was discharging from the middle ear was one thing, and an otitis which was not discharging was another lesion. Either nature or the surgeon changed its classification in our textbooks by producing a *discharge*. Today, we still act and think as though an otitic infection were a lesion confined to the tympanic cavity; and when the mastoid cells give evidence of involvement, we believe we are presented with a complication of the tympanic lesion. Why have we failed to recognize that any and every infection of the tympanic cavity means and implies an infection of all the air cells of the temporal bone?

In the early days of otology, Scheibe's painstaking serial sections, made on temporal bones of patients who had the so-called middle-ear infection, revealed at once that though the location of the suppurating lesion was clinically designated as of the *tympanic cavity*, in reality the *mastoid cells* were also involved to a greater or lesser degree in almost every instance. These studies were made on individuals who met with death accidentally or who died from an intercurrent disease while having a middle-ear suppuration. Since roentgenograms have become common, it is well known that they reveal the same fact. All infected ears give a roentgenogram of clouded, involved cells in the mastoid process.

Finally, if we pause to consider the nature of the infections with which we deal in the middle-ear spaces, it becomes increasingly difficult to understand them unless we realize that the invasion by bacteria reaches the parts by way of the blood stream. Such being the case in the majority of instances, we know that an infection thus located would not take root in the tympanum exclusively and later involve the

mastoid cells; but rather that the blood stream brings bacteria to the middle ear and all its adnexa which are embraced in the air cell system wherever this system has been prepared by predisposing factors to furnish soil for bacterial propagation.

Henceforth, therefore, in approaching our daily problem of the acutely infected middle ear, let us amend our designation to conform with the clinical and the pathologic facts, and realize that such an infection involving the middle ear will embrace all the air spaces of that structure. Actually we shall be dealing with an *infection of the temporal bone,* and not with an invasion of one or another of its anatomic subdivisions by contiguity.

This being so, the problem presented by an acute infection of the air spaces of the temporal bone presents a number of important clinical considerations:

I. What type of temporal bone does our patient present?

II. When shall evacuation of pus from the tympanic cavity be facilitated by surgical means; i. e., by incision into the drumhead?

III. Drainage having been established from the tympanic cavity by incision into the membrana tympani, when, during the ensuing course of the disease, is further surgery, namely, simple mastoidectomy, indicated by bedside signs and symptoms?

TYPE OF TEMPORAL BONE PRESENTED

In order to meet these bedside problems intelligently, there remains another fundamental factor to be stressed. It is essential, today, in handling infections of the temporal bone, to know as early as possible in the course of the disease exactly what type of temporal bone the given patient presents. It is necessary to know if it is a *pneumatized* temporal bone, if it is a *sclerotic* bone, or if we have to deal with an infection involving a *diploic type of* temporal bone.

From the time that roentgenology became an aid to otology, the roentgenogram has been used as an aid to diagnosis, and to furnish data which, added to other information, give substantiation to clinical judgment and help to fix the indications for surgical therapy. It is not at all unusual for the surgeon to turn to the roentgenologist, after he has carefully observed and recorded the bedside clinical evidence presented by his case, to procure for himself corroborative evidence, enhancing his bedside clinical observations, and to receive additional laboratory evidence to form his final opinion as to the presence or absence of indications for surgical intervention. I have no quarrel with such use of the roentgenograms. Thus used they are both informative and useful, particularly if the clinical evidence is not otherwise sufficiently convincing. Personally, I rarely use them for this purpose. Use the information which the roentgen ray brings to determine for yourself as early as possible in the course of the case the type of temporal bone your patient presents.

The courses of the disease are different in the three main types of temporal bones afflicted with an acute infection. The use of the roentgen ray is not to furnish data for indications to operate, but to give the clinician information, at the commencement of the lesion, as to the presence or absence of pneumatization, of sclerosis, or of diploe in the temporal bone. Endeavor to obtain this information about the time of the incision of the membrana tympani. This information, obtained and recorded, puts us at once into position intelligently to comprehend the clinical course which the given case will pursue, and eventually determines our therapeutic measures to combat the lesion. In a way it prognosticates the kind and nature of the lesion which in all probabilities will evolve.

To cite a few examples from actual practice: Take an acute middle ear infection following an exanthema which, upon otoscopic examination and other clinical evidence, demands an incision into the drumhead to afford middle ear drainage. We know that a sclerotic mastoid process cannot undergo coalescence. We are aware that a diploic mastoid process likewise undergoes coalescence. It has long been accepted that a pneumatized mastoid process, because of the mechanics of invasion that a bacterial infection entails, must undergo coalescence. Therefore, in our hypothetical case, once this information is at hand at the

time of the incision of the membrana tympani, we know what to expect.

If the roentgenogram shows a sclerosed mastoid process, we know that a clinical picture of what was heretofore designated as an acute mastoiditis cannot develop, and that the patient is at the beginning of an ear disease whose lesion will take a long time in healing. We are at once in a position to fortify our patient with the assurance that simple mastoidectomy will not eventuate.

On the other hand, should this early roentgenogram reveal a diploic type of bone, the persistence of the so-called infantile type of bone will give us reason to explain the unusual septic clinical course of the infection, and put us on guard to watch for metastatic lesions elsewhere in the body.

Finally, if we obtain information that pneumatization is at hand, we can reasonably expect in the course of the disease, unless it is soon checked, that coalescence will eventually develop and simple mastoidectomy may become necessary unless spontaneous resolution sets in.

There is no single means of meeting the problems of every-day otologic practice which ranks higher than the information obtained by the use of the roentgen ray *early* in the course of the disease.

Let us pause for a moment to digress and anticipate the problems concerned with the intra-cranial complications of bacterial infections of the temporal bone. Three factors stand out according to the type of the bone present in the given case. Lesions reach the vital intracranial structures by the large veins, the labyrinthine channels, or the dura and brain, but in the *pneumatized* type of bone usually this occurs by *contiguity;* and there is an interval of time which elapses between the lesion in the temporal bone and the lesion in the blood vessels, or the dura and brain. Hence, we may watch carefully the development of the coalescence, and pick the proper moment to interfere surgically. Such a case, under proper supervision, never will present a clinical picture which can take by surprise the surgeon in attendance. He knows what to expect, and he anticipates the further development of the lesion, halting the pathologic advance before the intracranial structures are involved.

If the bone is of the *diploic* type, lesions are developed intracranially by metastatic foci located intracranially. The lesion in such a bone is actually an osteomyelitis. The secondary lesions to be expected are naturally metastatic foci carried from the primary focus by the blood stream.

From a *sclerosed* mastoid process we may expect extension intracranially by contiguity. It is in cases presenting such bones that at the stormy commencement of the lesion, one must be on guard against involvement of the internal ear structures by contiguity.

This theme could be developed further, but it might lead us too far afield. In meeting the problems of everyday practice, these early roentgen plates, termed *identification* plates, are not used to diagnose a lesion, nor do they help to set indications for operation; but they do give a true picture of the type of bone which is at the seat of the infection, and furnish a key to the probable clinical course of the lesion. That much known early, therapy becomes obvious. The practicing otologist of today never is "surprised" with what meets him in the daily rounds of practice. He knows the potentialities which the case possesses, and is on guard.

CHRONIC TYPE OF INFECTION

If I pause here for a moment again to digress, it is to say a word about the clinical use of the word "chronicity" which still will leave us considering the type of temporal bone in which the lesion has located itself. Unfortunately, chronicity has developed, in otologic practice, from the observations made clinically of cases which run their course over a long period of time. A chronic lesion is not analogous to an acute lesion with only the difference in time before it ceases to be a lesion and becomes healed; but it is a distinct and separate clinical entity from the acute lesion. It is an entirely different kind of lesion. It does not resolve like an acute lesion; it heals by replacement of one tisue by another. It usually heals by stratified squamous epithelium replacing mucous membrane. It happens to occur in a

different type of bone than does the acute lesion; and one second after its onset, it is chronic in nature and remains so until it terminates either through the efforts of nature or because of surgical help. We must cease considering a chronic infection of the middle ear structures as one which began actutely and then, instead of resolving, dragged itself along as a chronic lesion. The designation "chronic" should mean to us a specific type of lesion having no relationship whatsoever to periods of time.

The recognition of this fact at the bedside will meet another problem of every otologic practice, and will at once change the situation as to the comprehension of the lesion. Patients will not complain that this or that friend, who was taken sick at about the same time as they, has been cured while they have an ear which seems to be discharging pus indefinitely. The physicians who realize what I am trying to point out will be in a position to state unequivocally, from the very commencement of the case, that they have a lesion of the ear which by its very nature is prone to last a long time. Such a prognosis depends upon the finding of a sclerosed temporal bone at the time of the onset of the ear trouble, and the otoscopic picture which will show shrapnellian perforations or drumhead defects of larger dimensions and mostly of marginal location.

There is only one exception to this statement, the recognition of the acute necrotic type of otitis described by Wittmaack. Here is a pneumatized type of temporal bone, and an acute coalescent mastoiditis may develop. In this type of case, which mostly follows the exanthema, there is loss of tissue of the drum, areas of ulceration over the promotory, occasionally including bone necrosis, and areas of bone necrosis in the region of the attic, often with perforations through Shrapnell's membrane. Cases of this type will run a long course and continue to discharge in spite of there being pneumatization present. Should a mastoiditis develop in such an ear and a simple mastoidectomy be performed, the middle ear will often continue to discharge after the operation for an indefinite period of time,—until the necrotic areas are discharged by nature and covered over by stratified squamous epithelium whose origin is the dermal layer of the membrana tympani or is the result of replacement ingrowth of epithelium from the dermal coverings of the aditus, or external auditory canal walls.

With the first roentgen plate giving a sclerosed bone, the lesion with which we are dealing will usually last a long time and of necessity be designated "chronic". Two groups prevail; one, chronic mastoiditis involving bone necrosis; the other, in which there will be an ingrowth of stratified squamous epithelium that will travel inward to replace mucous membrane of parts of the middle ear, sometimes penetrating into the antrum through the aditus and, to a larger or lesser extent, into the mastoid process, forming a lesion known and designated as *cholesteatoma*. Scientifically, they constitute a large group of cholesteatoma cases which we call pseudo- or secondary cholesteatoma because true cholesteatoma is congenital.

Finally, before leaving this question of the first roentgen plate and the information it furnishes, there remains one other fundamental factor to be discussed because of its bearing on everyday practice. I direct attention to the continuance of an *otorrhea* for a long period of time in a case with a pneumatized temporal bone. Heretofore, we have considered pneumatization only as it presents itself in the mastoid process of the temporal bone. We have entirely overlooked the pneumatization which could, and often does, develop in the petrosal pyramid.

THE PETROSAL PYRAMID

When such complete pneumatization has taken place and an infection has developed in the bone, followed by coalescence of the cell walls of the mastoid process, often a degree of coalescence also takes place in the cellular elements of the petrosal pyramid. If such a lesion is encapsulated, it may become a threat to life itself in the potentialities it possesses to erupt intracranially. Often, instead of becoming encapsulated and shut off from the tympanic cavity, there are fistulous tracts leading from the tympanic cavity toward and into the area of coalescence of the cellular structure of the

petrosal pyramid. The original roentgen plate, taken at the early stage of the clinical course of the case, gives the key to the possibility of this occurrence.

A simple mastoidectomy should result in a cure of a coalescent mastoiditis and this cure should embrace not only the removal of the threat to life which acute mastoiditis presents, but it should result in a dry middle ear and a healed, functioning drumhead. Heretofore, when presented with such a case, there resulted failure to procure the dry middle ear and functioning membrana tympani, and it was the universal custom to subject the patient to a revision of the mastoidectomy after a period of time. This is a very pressing problem in everyday practice. With the newer knowledge and a comprehension of the infection in relation to the type of bone involved, one will solve this problem by looking for the seat of the trouble in the petrosal pyramid. Recently, one of my associates injected lipiodol in such a case. This child had a pneumatized mastoid process upon which a simple mastoidectomy was performed, but healing was not obtained, nor a dry ear procured. Revisions of the mastoidectomy were undertaken without success. Secondary roentgenograms showed a cleared mastoid process, but the injection of lipiodol into the middle ear demonstrated that it penetrated into the petrosal pyramid. The cause of the persistent otorrhea in this case was a purulent fistulous tract from an area of coalescence in the petrosal pyramid, which emptied into the middle ear and discharged from thence through the external auditory canal. The patient is curable, once the lesion is understood.

TRAUMATIC CASES

Finally, there is another aspect of otologic diagnosis in which the underlying bone structure plays an important part in determining the condition presented by a given chronically discharging ear. I refer to cases which come under review in the course of traumas. Where after an accident a patient claims that there has resulted from an ear which he alleges was previously dry and normal, a chronically discharging middle ear, the underlying bone structure may hold the key to the question as to whether or not that patient is or is not malingering.

Granted a previously normal ear, with no changes, it is naturally assumed that the bone will be either pneumatic or diploic. If it is sclerotic, there are even chances that, during the period of life when the patient was prone to the exanthemata, a chronicity would have started. Hence, when a patient who has undergone an ear trauma presents a chronically discharging ear, with pneumatization or diploic bone present, there is presumptive evidence that the trauma is the etiologic factor in the production of the chronicity. On the other hand, should sclerosed bone be demonstrated, there are strong probabilities that the chronicity antedated the alleged ear trauma.

I state this as a clear-cut opinion. In reality, there are qualifying conditions and additional factors to be considered. When trying to ascertain whether a given chronicity had its origin in a trauma, it is well to take into consideration the question of the bone structure shown by the temporal bone in the given case.

CHRONIC APPENDICITIS VERSUS MUCOUS COLITIS

By Carroll Deane Smith, M.D., Paterson, N. J.

Read on May 2, 1935, before the Section on Gastroenterology at the 169th Annual Meeting of The Medical Society of New Jersey in Atlantic City

The association of the chronic appendix syndrome with the varieties of colitis, particularly the so-called mucous or membranous colitis, has been noted many times. However, the etiological relationship between these conditions frequently offers difficult and important problems, and the expectant therapeutic benefit following an appendectomy has often enough been conspicuous by its absence. In fact, some cases have been materially aggravated.

This paper is an attempt to evaluate as far as possible the results following appendec-

tomy in a series of twenty-six cases in which colitis was either not suspected at all, or was only diagnosed following the appendectomy, and in the majority of which it was hoped that an amelioration of the colitic symptoms would follow the appendectomy.

The evaluation of the removal of the chronic appendix should in all fairness be based upon the subsequent improvement or disappearance of the symptoms for which the appendix was removed. That the anticipated relief of the symptomatology is not nearly so frequently achieved is distinctly and succintly forced to my attention by a group of *twenty-six* patients whom I have endeavored to treat in the past few years, all of whom having had previous primary operations for the removal of a suspected chronic appendix.

A brief reference to the literature on this subject tends to show that an intimate etiological and symptomatic relation has been recognized between these two conditions, but the question is in doubt as to which one is the more important in the causation of the symptoms.

Mummery states that chronic appendicitis can apparently cause mucus colitis in three ways, namely (1) by the inflamation spreading from the appendix directly to the caecum, ascending colon, transverse and descending colon; (2) as a result of appendicitis, adhesions may form between the appendix or caecum and other parts of the colon, usually the sigmoid, and (3) the inflamed appendix as a septic focus which is constantly discharging septic material into the colon. The latter method of which he is convinced acts most commonly as a cause of mucous or membranous colitis. He states that extremel ysatisfactory results have been attained subsequent to appendectomy in a group of selected cases where the colitic symptomology pointed to a chronically inflamed appendix as the etiologic factor.

On the other side, in a series of cases reported in his books, Bastedo states that practically never is the appendix the inciting cause of this type of colitic condition, but is the result of the extension and involvement resulting from inflammatory reactions distally in the colon, becoming a part and parcel of the primary condition, and he advocated removal of the appendix only in those cases showing definite appendiceal symptoms, choosing other therapeutic measures in preference to operative procedure in the doubtful cases.

The following excerpt from Bassler is of interest. He states, quotation. "It must be perfectly logical to anyone to consider hat the large number of cases of acute and chronic diseases of the appendix must have its origin in the bacteriology of the intestinal canal. My belief is that the main cause of chronic appendicitis is an intestinal toxemia, and this explains why it is that often after appendices are removed the symptoms continue just as before, because removal of the appendix will not cure intestinal toxemia. There is feeling nowadays that in an instance of intestinal toxemia and diseased appendix, the removal of the appendix will have a beneficial effect upon the intestinal toxemia. This is true in only the minority of cases. The great majority of cases are the other way, namely, that the intestinal toxemia is primary and not removed by operation; and the removal of the appendix merely removes a resulting condition and not the actual cause."

There are many writers who are more conservative concerning the causative or etiological relationship between the chronic appendix and mucous colitis, stating that a chronic appendicitis may be a cause, but making no definite claims. Stating only that appendectomy is occasionally of material aid as a therapeutic measure.

DISCUSSION OF A SERIES OF 26 CASES

In presenting the high points in the analysis of these cases, I wish it to be understood that it is not my intention to infer that operative procedures carried out on many of these patients were unnecessary. However, I do intend to stress the fact that more complete preoperative and postoperative care and consideration is an important factor and aid in the correct diagnosis and the alleviation of these patients' symptoms. I do not wish to quote the cases, but will speak of them collectively.

In taking the histories of these patients, I made every effort to obtain the patients' pre-

operative symptomatology without conflicting with their symptomatology upon presentation to me. This was, of course, difficult, but sufficient of them were intelligent enough in regards to symptoms to enable me to draw some conclusions.

The ages of this group varied from 21 years to 66 years. The operations were performed from three months to eight years previously. The dominating preoperative symptoms obtained were:

1. Abdominal pain, griping or cramping in character, inconstant as to position, occurring at no especial time, occasionally helped and occasionally aggravated by eating.

2. Chronic constipation, with recurrent attacks of a mild diarrhea.

3. Occasional nausea and frontal headache, but none had vomited.

4. An aversion to certain food was elicited from all, but no constancy as to what food, although most of them came within the vegetable kingdom.

5. A general sense of poor health evidenced by chilliness, lack of vitality; bad taste in the mouth, tiring easily, nervous, etc.

Here I would like to call attention to the fact that none of this series claimed umbilical pain or a temperature associated with these attacks of pain. Also, that only a few had gastro-intestinal fluoroscopy, or x-ray plates, or opaque enemata. None had been proctoscoped, although a few had been examined digitally per rectum.

During the hospitalization of these patients, there was a marked improvement of their condition which may be assumed to be due to the rest, quiet, freedom from anxiety, proper diet, and eliminative care incidental to operative care. One patient, however, had a terrific return of his symptoms the day before he was to be discharged from the hospital.

After leaving the hospital and after being dismissed by the surgeon as recovered surgical cases, these patients were symptom free for a period of from three weeks to eight months, the average being about three months, whereupon they noticed a return of the symptoms which had previously necessitated operation.

Upon returning to their physician, they were advised in many cases that the recurrence of the symptoms was due to "healing processes" within the abdomen, or to slight adhesions, and that their symptoms would soon disappear. Such, however, was not the case, and with the passing of time these patients migrated from one doctor to another, and being increasingly disappointed in the results obtained, finally become relegated to the "nervous indigestion", neurasthenic, hypochondriac, neurotic, nervous dyspeptic, or other similar classification, most of them becoming essentially egocentric.

Time limitation prevents a full and detailed description of the symptoms of each case, so here only those symptoms predominating throughout the group will be given.

SYMPTOMS

Here you will notice a more accentuated repetition of previous symptoms as given under the preoperative state.

1. A tendency towards bloating, eructations and griping pains, especially in relation to the large bowel, such as the left upper quadrant, right upper quadrant, the transverse colon and the proximal portion of the descending colon, in the order of their frequency, occurring spasmodically and lasting from a few minutes to several hours. Partaking of food had no particular bearing on relieving or causing pain, nor did night or day seem to show much difference as to the occurrence of these attacks, although several complained of being awakened by these pains.

2. Constipation marked with recurrent short attacks of diarrhea, at which times there was passed "slime" or mucus, which was in some cases tinged or well impregnated with blood.

3. The majority had either noticed mucus floating at stool or had passed strings of mucus with what they considered a relatively normal bowel movement for them.

4. Foul breath, especially upon arising in the morning, and a continually coated tongue.

5. Occasional unilateral, temporal, or frontal headache, and spots before the eyes.

6. General sense of poor health, lack of ambition, logginess, poor reaction to food, easily affected by cool weather, tiring easily,

and over reaction from nervous and mental stimuli.

The more important physical findings were:

1. The abdomen usually presented the presence of gas at some point in the large bowel, from the caecum up to the distal part of the descending colon, more often in the hepatic or splenic flexure.

2. Deep palpation and pressure over the sigmoid was invariably sensitive, causing pain; and the upper portion of the sigmoid could be felt as a firm contracted portion of the gut, even after catharsis or enemata.

3. A thickly coated tongue with marked serrations and enlargement.

4. Vasomotor instability as evinced by apprehension, heart consciousness, eructations, tremor, pupillary dilatation, etc.

5. Dermographia present.

6. Except for traces of indican the urine was negative.

7. Usually a moderate amount of anemia was present, the hemoglobin being between 65 to 80 per cent, and the blood count otherwise normal.

8. The blood pressure in most cases under 120, and the heart rate somewhat accelerated.

9. The proctosigmoidoscopic examination usually revealed a thickened, somewhat reddened mucous membrane, some enlargement and tortuosity of the visible blood vessels, and occasionally, especially in the rectum, a redundancy of the mucosa of the bowel. Close inspection shows small minute scarified areas in the mucous membrane; and active reaction with bleeding from light traumatization from wiping or instrumentation. The presence of an amount of mucus on the abnormal mucosa depended usually upon the patient's condition at the time of examination. Examined one day, a small amount of fairly well desiccated mucus bridging and looping the bowel wall might be seen, another day the rectum and sigmoid might show large amounts of fluid mucus. If dehydrated, the mucus was hard and dry and when removed from the mucous membrane, caused bleeding and subsequent ulceration. It is infrequent in this type to see the blood-stained mucus unless there has been marked aggravation of the rectosigmoid and descending colon, or a desiccated piece of mucus has recently been pulled away from the bowel wall; in which cases one occasionally may see small ulcerations. Either a hypertrophic or an atrophic musoca will be seen, depending on the duration of irritation.

10. When the economic situation was such that the x-ray might be employed, the opaque enema showed enlargement and tendency towards redundancy of the colon with poor haustrations, especially in the left transverse and descending colon. The picture after evacuation usually showed fair emptying, with spasticity of the distal portion of the descending colon and sigmoid.

TREATMENT

With these findings it is only reasonable to assume that active treatment directed toward the colon, such as a bland non-irritative diet, antispasmodics, medication such as of the kaolin and bismuth type for mucus absorption; supportive tonics, rest, medication through enemata, and direct medication through the proctosigmoidoscope, should produce a satisfactory result in the attempt to alleviate the symptoms and distress. This I have found to be so, particularly in those who were more faithful to themselves in therapeutic routine.

All this leads to several suggestions that should be used preoperatively to further diagnosis and evaluate the necessity of appendectomy.

1. A complete history and physical examination with indicated laboratory procedures.

2. A satisfactory proctosigmoidoscopy.

3. Where possible, a complete gastro-intestinal series of x-ray and fluoroscopic examinations, completed by an opaque enema with a picture of the distended colon, and one taken after an attempt has been made by the patient to evacuate the enema.

4. A bimanual rectal or digital examination to ascertain the presence of an irritable appendix.

5. Stool examination for ova, bacteria or amoeba.

6. Adequate therapeusis directed to the colon per mouth and rectum, such as stated in the preceding paragraph.

After these measures have been carried out and given a fair trial and it is then considered to the patient's advantage that an operation for the removal of the appendix be performed, the following postoperative care is suggested:

1. Monthly, or more frequent proctosigmoidoscopic examinations as long as considered necessary, then periodic examinations.

2. Therapeusis directed to the colon to offset reaction and pathological changes already present, supposed to be relieved by appendectomy.

3. Instructions to the patient to observe every stool for mucus, color, pus, blood, etc.

4. Advise the patient as to the tendency towards chronicity of his condition and the importance of his learning to care for his health, and that this condition has a marked tendency to recur even after many years of freedom from symptoms.

COMMENT

In conclusion, I would like to bring out two important factors concerning the diagnosis and treatment of this class of patients.

1. The greater routine use of the proctosigmoidoscope in the hands of a competent operator in the examination of this "nervous indigestion" class of patients is invaluable as an aid in the diagnosing of the true cause of their symptomology, and the subsequent therapeusis directed towards the colon, appendectomy might be avoided.

2. Should appendectomy be performed in these cases, it should by all means be considered merely as a fractional or integral part of the therapeutic array; and the colitis, be it primary or secondary, should have the benefit of properly directed treatment to the rectum, sigmoid, and colon.

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DISCUSSION

Dr. Rudolph Gorsch, Adjunct Professor of Proctology, Polyclinic Medical School and Hospital, New York City: The question of surgical interference in the cases of so-called mucous colitis is an important one. The term "mucous colitis" needs revision, since it includes a group of poorly defined clinical syndromes as spastic colitis, myxoneurosis, irritable colon, etc. It would perhaps clairfy this phase of the colitis problem if the term were dropped entirely.

We consider the *neuropathic* and *psychogenic* element to be the underlying pathology in so-called mucous colitis; and the *functional* derangement of the motor and secretory apparatus of the gastro-intestinal tract as dependent upon it. The greater part of the symtomatology can be explained on this basis.

The importance of Dr. Smith's paper is to stress the fact that the removal of the so-called chronic appendix, to say nothing of other suspected foci of infection, in these cases frequently results in disappointment and may even make there patients worse.

We believe that, with the exception of definite acute processes, there should be a very well-defined indication for surgical interference; and in our experience the three following definite pathological conditions of the appendix warrant its removal:

1. Constriction of the neck of the appendix usually with the presence of a fecolith.
2. A definitely kinked appendix.
3. A definitely retrocecal appendix.

One should not wax too enthusiastic over the expected clinical improvement.

I desire to thank the Chairman, Dr. Gerendasy, and the members of the section for the privilege of participating.

Dr. Frank C. McCormack, Holy Name Hospital, Teaneck, N. J.: I am deeply impressed with the importance of the subject which Dr. Smith has presented for our consideration. His twenty-six cases (which is a convincing number) of so-called "mucous colitis", in which the appendix was removed as the cause of the disease, without any benefit to the patient, is certainly a challenge to the therapy of the surgeon and to the diagnostic ability of the referring physician. Dr. Smith modestly states that he does not mean to infer that these twenty-six cases were subjected to unnecessary surgery. He not only infers that idea, but in my opinion, he unquestionably proves that fact by his careful and complete check-up on both the preoperative clinical history and subsequent clinical signs and symptoms of these twenty-six cases.

Personally, I have never seen a case of chronic appendicitis associated with mucous colitis; or have I seen a case of mucous colitis in which the appendix could be designated as the real cause of the mucous colitis.

The term "mucous colitis" represents perhaps a condition or a syndrome rather than a definite disease. I do not know whether anyone has ever presented pathological data sufficient to properly call this excess mucus in the stool a true colitis.

There should be a more explicit term to designate this condition with which we are all familiar.

Drs. Jordan and Kiefer, of the Lahey Clinic, term this condition "irritable colon". Though this term is not entirely descriptive of the condition, it does give a suggestion of a disordered constitutional state, the chief symptoms of which are confined to the colon.

Bastedo states, "There is much difference of opinion about its character, and no agreement about its etiology." On the other hand, Rankin says, "Mucous colitis or 'irritable colon' is purely neurogenic and the mucus produced is a hypersecretion." The preponderance of present evidence favors this later hypothesis, as it is strongly supported by similar opinions of Bargen, Jordan, Barker, Wilkinson, Bank, and Lichty.

The condition is much more common in women than men. It seems to occur in particular types of patients that have abnormal nervous systems. They are, as Dr. Smith states, "irritable, excitable, or depressed and melancholic". All of them are introspective, self-centered and usually think or talk about nothing but their intestinal symptoms. These outstanding subjective characteristics should put the examining physician on his guard. To subject this type of neurotic individual to the shock and psychical strain of an unnecessary operation certainly adds oil to the fire instead of quenching the blaze. I also have seen deplorable cases when I was in general practice that had been subjected to various operative procedures such as "straightening out kinks" in the colon; breaking up adhesions; plastic operations on the mesocolon for coloptosis, as well as appendectomies. They all failed to restore normal bowel function but took their toll on the nervous system of the patient.

Dr. Smith quoted Basler's opinion "that the removal of the appendix (if pathological) merely removes a resulting condition, and not the actual cause". This opinion is substantiated by the radical case reported in Bastedo's text-book, in which the colon was completely removed by Lane, of England, and the ileum anastomosed to the sigmoid. All the symptoms of the mucous colitis persisted even after this heroic surgery.

In a pointed way, Dr. Smith's paper conveys the impression that mucous colitis is a strictly medical condition, and that surgery has little or no part in its treatment. I heartily agree with him.

Dr. Smith's paper stresses the need of careful history taking; the gross and microscopic examination of the anus and retcum; and most important of all, the proctoscopic and sigmoidoscopic examination along with x-ray study. Of his twenty-six cases, only two or three had been examined digitally by rectum or studied by fluoroscope and x-ray, and not one patient was proctoscoped. These facts sadly bring home to us the humiliating results of careless practice of medicine.

I regret that Dr. Smith's paper is not being presented to the Section on General Medicine, rather than before the Section of Gastroenterology. This report of such gross omissions would be far more appropriate, more effective in end results there, than before this specialized group. I have in mind the younger physicians.

I would ask Dr. Smith to mention in his summary his opinion of thyroid gland pathology and intestinal allergy, as probable factors in the etiology of this type of colitis. Also, what is the value of DeCoste's dilute sulphuric acid treatment, and the more recent use of dihydronal; also what place does medicated colonic irrigations hold in the treatment of this condition.

I compliment Dr. Smith, not only on his excellent and edifying paper, but especially on his emphatic warning to over-enthusiastic surgeons, and on his plea to the general practitioner for a more careful history, and complete local examination in all types of colonic pathology.

COMMON DISORDERS OF THE DIGESTIVE TRACT

A CLINICAL AND ROENTGENOLOGICAL STUDY OF FIVE HUNDRED PRIVATE CASES

By SIGURD W. JOHNSEN, M.D., Passaic, N. J.

Read before the Gastro-enterological Section of The Medical Society of New Jersey at the Annual Meeting in Atlantic City, May 2, 1935.

This study is based on the examination of five hundred consecutive patients presenting themselves with digestive complaints in my office practice.

A complete history, physical examination, gastric analysis, hemoglobin determination, urine analysis, proctoscopic examination, and Roentgenological examination was done in every case.

1. ORGANIC DISEASE GROUP

Organic disease of the digestive tract was found in 109 cases, an incidence of 21.8 per cent. This is a high percentage in an ambulatory group, but we feel that thorough examination is responsible for detecting many early lesions.

Duodenal ulcer was found to be the most frequent lesion. It occurred in 51 cases, or

46 per cent; males 39 and females 12. The greatest incidence occurred in the 30-39-year group.

Cholecystitis was the next most frequent lesion. It was found in 40 cases, or 36.6 per cent; males 7 and females 33. The greatest incidence was in the 50-59-year group.

TABLE 1. CASES OF ORGANIC LESIONS

		No. of Cases	Percentage of Cases
Organic Lesions		109	21.8
Type			
Ulcer		53	47.7
Duodenal ulcer	51		
Gastric ulcer	1		
Gastric ulcer & Cholecystitis & Cholelithiasis	1		
Chronic Cholecystitis		40	36.6
Cholelithiasis in 17			
Duodenal Diverticulosis in 1			
Carcinoma		9	8.2
Stomach	3		
Colon	2		
Rectum	2		
Recto-sigmoid	2		
Diverticulosis		4	3.6
Ulcerative colitis		2	1.8
Esophageal ulceration		1	0.9

Carcinoma occurred in 9 cases, or 8.2 per cent; males 4, and females 5. The greatest incidence was in the 60-69-year group. Table I is a tabulation of the organic lesions group.

It has been impossible to associate any definite symptom complex with any one type of lesion. Frequently the symptoms would indicate a duodenal ulcer, but the findings would demonstrate a cholecystitis. It should, however, be kept in mind that most of these cases were seen in the early stages of disease.

TABLE 3. SYMPTOMS SHOWN IN 109 CASES OF ORGANIC LESIONS

	Symptom	No. Cases	Percentage
1.	Epigastric pain	63	58
2.	Constipation	56	51
3.	Tympanities	50	46
4.	Belching	34	31
5.	Abdominal pain	24	22
6.	Headache	20	18
7.	Nausea	18	17
8.	Epigastric distress	15	14
9.	Vomiting	15	14
10.	Back and shoulder pain	10	9
11.	Dizziness	9	8
12.	Malaise	8	7
13.	Blood stools	5	5
14.	Indigestion	5	5
15.	Abdominal distress	4	4
16.	Loss of appetite	3	3
17.	Loss of weight	2	2
18.	Nervous	2	2
19.	Diarrhea	2	2
20.	Fainting	1	1
21.	Pain in joints	1	1
22.	Insomnia	1	1
23.	Hematemesis	1	1

TABLE 2. AGE DISTRIBUTION IN THE CASES OF ORGANIC LESIONS

Ages	Ulcer	Cholecystitis and Lithiasis	Carcinoma	Diverticulosis	Colitis
20 to 29	11, or 21%	5, or 13%			
30 to 39	17, or 32%	7, or 18%			
40 to 49	16, or 30%	8, or 20%		1, or 25%	1, or 50%
50 to 59	5, or 9%	12, or 30%	1, or 11%	1, or 25%	
60 to 69	2, or 4%	8, or 20%	6, or 67%	2, or 50%	1, or 50%
70 to 79	1, or 2%		2, or 22%		
80 to 89					
90 to 99	1, or 2%				
Sex					
Male	39, or 74%	7, or 18%	4, or 44%	3, or 75%	
Female	14, or 26%	33, or 82%	5, or 56%	1, or 25%	2, or 100%
Marital State					
Married	34, or 64%	33, or 82%	8, or 89%	3, or 75%	2, or 100%
Widowed	5, or 9%	5, or 13%	1, or 77%	1, or 25%	
Single	14, or 26%	2, or 5%			

The symptom most frequently complained of in this group was epigastric pain, which occurred in 63 cases, or 58 per cent. Constipation was the next most frequent complaint, occurring in 56 cases, or 51 per cent. Table II is a tabulation of the symptoms in their order of frequency.

Conclusions:

First: Organic disease of the digestive tract in ambulatory patients occurs more frequently than is commonly believed.

Second: The symptom complex is of little value in making an accurate diagnosis in the early stages of digestive disease.

Third: A complete correlated examination is essential to the early diagnosis of digestive disease.

2. FUNCTIONAL DISORDERS

Functional disorders occurred in 350 cases, an incidence of 70 per cent. The most common disorder was spastic constipation, which occurred in 175 cases, or 50 per cent. Irritable colon was the next most frequent disorder found, occurring in 108 cases, or 30.8 per cent. Irritable colon with spastic constipation comes next, occurring in 63 cases, or 18 per cent. Tables 4 and 5 show the classification of functional disorders and the relation to age, sex, and marital state.

FUNCTIONAL DISORDERS

TABLE 4. CASES OF FUNCTIONAL DISORDERS

	No. of Cases	Percentage
All types of functional disorders	350	70
Spastic constipation	175	50
1. Delayed gastric emptying in 6		
2. Cecal stasis in 3		
3. Ileal stasis in 1		
Irritable colon	108	30.8
1. Delayed gastric emptying in 2		
2. Cecal stasis in 1		
3. Ileal stasis in 1		
Irritable colon with spastic constipation	63	18
Delayed gastric emptying	2	0.6
1. Redundant colon, Achlorhydria and spinal scoliosis in 1		
2. Congenital low cecum in 1		
Atonic constipation	1	0.3
Ileal stasis	1	0.3

When we study the chief complaints of this group, as shown in Table 7, and compare them with those of the organic lesions group in Table 3, we note a marked similarity. Except for epigastric pain, which was present in 58 per cent of the organic lesions, and in only 12 per cent of the functional disorders, the other complaints are about as frequent in one group as in the other.

The Roentgen findings in the functional disorder group are identical with those of the organic lesion group except for the specific signs of ulcer niche, or absent shadows on the cholecystogram, etc. In the irritable colon cases we have hypermotility, increased spasm, both gastric and colonic. In the constipation cases we have marked colonic spasm with stasis.

There were 35 cases in whom extra-gastric disease was found in this group, an incidence of 10 per cent. These are tabulated in Table 8.

TABLE 5. AGE DISTRIBUTION IN FUNCTIONAL DISORDERS

Ages			Marital State		
1 to 9	1	0.3	Married	245	70
10 to 19	10	3	Widowed	17	5
20 to 29	71	20	Single	86	24
30 to 39	100	28	Divorced	2	0.6
40 to 49	86	25			
50 to 59	46	13			
60 to 69	23	7	*Sex*		
70 to 79	12	3			
80 to 89	1	0.3	Female	236	67
			Male	114	33

TABLE 6. CONFIRMATION OF DIAGNOSIS BY OPERATION

	No. of Cases	Operated	Percentage
Cholecystitis	40	14	32.5
Ulcer	53	7	13.2
Carcinoma	9	4	44.4
Esophageal ulcer	1	1	(Esophagoscopy)

TABLE 7. SYMPTOMS SHOWN IN 350 CASES OF FUNCTIONAL DISORDERS

	No. of Cases	Percentage
1. Constipation	208	59.0
2. Tympanities	177	51.0
3. Belching	148	42.0
4. Headaches	117	33.0
5. Abdominal pain	97	28.0
6. Malaise	84	24.0
7. Epigastric pain	75	21.0
8. Dizziness	47	13.0
9. Epigastric distress	44	12.0
10. Nausea	40	11.0
11. Pain in back	28	8.0
12. Vomiting	27	8.0
13. Indigestion	17	5.0
14. Nervousness	16	5.0
15. Abdominal distress	15	4.0
16. Pain, stiffness, or swelling of joints	10	3.0
17. Loss of appetite	8	2.0
18. Heartburn	7	2.0
19. Loss of weight	5	1.0
20. Rash	5	1.0
21. Palpitation	5	1.0
22. Abdominal cramps	4	.8
23. Coated tongue	3	.8
24. Fainting	3	.8
25. Hematemesis	2	.6

Conclusions:

First: Functional disorders occur with far greater frequency than organic disease and cause the same distress.

Second: Functional disorders are probably the early manifestations of organic disease, and not simply nervous disorders.

Third: Treatment of functional disorders should be directed toward elimination of the causes, and should be just as thorough as for organic disease.

TABLE 8. ORGANIC DISORDERS IN FUNCTIONAL GROUP

Uterine fibroid	3
Tuberculosis	3
Myocarditis	3
Migraine	3
Secondary anemia	2
Syphilis	2
Spinal scoliosis	2
Arthritis	2
Pyelo-nephritis	2
Pregnancy	1
Angina pectoris	1
Psychosis	1
Manic depressive psychosis	1
Congenital hip disease	1
Metrorrhagia	1
Chronic mastoiditis	1
Petitmal	1
Pernicious anemia	1
Carcinoma of breast	1
Pyo-hydro-nephritis	1
Bronchitis	1
End-obliteratus arteritis	1
	35

3. NORMAL GROUP

In 41 cases, or 8.2 per cent, all the findings were normal in respect to the gastro-intestinal tract. However, disease elsewhere was found in 15 cases. The classification and detailed data for this group are found in Tables 9 and 10. The incidence of extra-gastric disease in this group was far greater than in the functional disorder group.

The symptoms complained of in this normal group, as shown in Tables 9 and 10, were similar to those of the other group.

Conclusions:

First: The number of normal cases in this series was very low.

Second: The incidence of extra-gastric disease was high, and the symptoms complained of were probably reflex and nervous.

Third: Symptomotology is of very little help in the diagnosis of digestive disorders.

TABLE 9. NORMAL GASTRO-INTESTINAL TRACTS

Symptoms	No. of Cases	Percentage
Total No. of cases	41	8.2
Tympanities	22	53.6
Constipation	19	46.3
Belching	18	43.9
Abdominal pain	12	29.2
Epigastric pain	9	21.9
Malaise	9	21.9
Headache	8	19.5
Nausea	6	14.6
Dizziness	5	12.1
Epigastric distress	5	12.1
Vomiting	4	9.7
Pain in back	3	7.3
Nervousness	3	7.3
Diarrhea	2	4.8
Abdominal distress	1	2.4
Indigestion	1	2.4
Fainting	1	2.4
Pain in joints	1	2.4

OTHER FINDINGS

Pregnancy	2
Angina pectoris	2
Spinal scliosis	2
Redundent colon	2
Achlorhydria	2
Lymphatic leukema	1
Arthritis	1
Enlarged heart	1
Parkinson's disease	1
Pyelo-nephritis	1

TABLE 10. AGE AND SEX DISTRIBUTION

Ages	No. of Cases	Percentage
10-19	2	4.8
20-29	8	19.5
30-39	11	26.8
40-49	5	12.1
50-59	7	17.0
60-69	7	17.0
70-79	1	2.4

Sex		
Female	25	60.9%
Male	16	39.0%

Marital State		
Married	29	70.7%
Single	12	29.2%

4. ANATOMICAL ANOMALIES

Anatomical abnormalities of the digestive tract were found in 130 cases, an incidence of 26 per cent. These are tabulated in Table 11. The most frequent anomaly was redundant colon, which occurred in 63 cases. The next most common was congenital low cecum, found in 30 cases. Redundant colon with congenital low cecum was found in 25 cases.

In Table 12 the relationship of the anatom-

TABLE 11. ANATOMICAL ABNORMALITIES

Total No. of Cases—130 or 26 per cent	
Redundant colon	63
Congenital low cecum	30
Congenital low cecum Redundant colon	25
Congenital high cecum	2
Redundant colon Congenital high cecum	2
Non-rotated colon	1
Redundant colon Congenital low cecum Hypofixation of the splenic flexure	1
Redundant colon Mobile cecum	1
Diverticulosis	4
Duodenal diverticulum	1

cases, or 31 per cent. It is in this group that we find constipation as the leading disorder. In the organic disease group, we find 17 anatomical anomalies, or 15 per cent. However, we find in the normal group 3 cases of redundant colon, and 1 case of congenital low cecum, an incidence of 7 per cent.

Conclusions:

First: Anatomical anomalies of the digestive tract occur most frequently in cases of constipation.

Second: Anomalies occur in normal cases without producing abnormal gastro-intestinal findings.

TABLE 12. RELATIONSHIP OF ANATOMICAL ANOMALIES TO ALL GROUPS

Group I—Organic Lesions—109 Cases	Ulcer (53)	Cholecystitis & Lithiasis (40)	Ulcerative Colitis (2)	Diverticulitis (4)
Redundant colon	3	4	0	0
Congenital low cecum	1	1	1	0
Redundant colon and congenital low cecum	1	0	0	0
Redundant colon and congenital high cecum	1	0	0	0
Duodenal diverticulum	0	1	0	0
	6—11%	6—15%	1—50%	4

Total No. of Anatomical Anomalies in Group I—17 or 15%

Group II—Functional Disorders—350 cases

	Spastic (175) Constipation	Irritable Colon (108)	Irritable Colon & (63) Constipation	Delayed Gastric Emptying	Atonic (1) Constipation
Redundant colon	25	8	19	1	1
Congenital low cecum	14	6	5	1	0
Redundant colon and congenital low cecum	11	2	11	0	0
Redundant colon and congenital high cecum	1	0	0	0	0
Redundant colon and mobile cecum	1	0	0	0	0
Non-rotated colon	1	0	0	0	0
Congenital high cecum	0	2	0	0	0
Congenital low cecum, redundant colon and hypofixation of the splenic flexure	0	0	1	0	0
	53—31%	18—17%	36—57%	2—100%	1—10%

Total No. of Anatomical Anomalies in Group II—110 or 31 %

Group III—Normal Gastro-Intestinal Tract—41 Cases

Redundant colon	2
Congenital low cecum	1
	3

Total No. of Anatomical Anomalies in Group III—3 or 7%

ical anomalies to the three groups is shown. The greatest percentage occurs in the functional disorder group, where we found 110

Third: There is no definite symptom complex which can be associated with any definite type of anatomical anomaly.

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WHY IS HEALTH INSURANCE NOT HEALTH INSURANCE?

By F. F. Borzell, M.D., Philadelphia, Pa.

Read before the Burlington County Medical Society, April 10, 1934

Health insurance is being intensively promoted in sales talks by well-meaning enthusiasts who know little of their wares. Health insurance has indeed a pleasing sound. It implies something that the public would gladly purchase if it were possible. Of course, health is one of the most valuable assets, if not the most valuable, that one can possess. It is a possession that, once lost, we become frantic to regain. This is so true that the physician is time and time again implored to spare no cost when a loved one is lying at death's door. How willingly the loved ones spend anxious days and sleepless nights, waiting for every whisper of hope from that faithful friend, their family doctor. How they count the hours for his return, hoping he may find the patient improved; or, perhaps, when he has exhausted all his resources he suggests further aid—perhaps in the form of a consultation, x-ray or laboratory studies, a surgical operation, or some skilled specialist. They unhesitatingly urge the doctor to spare no expense.

That is the picture that probably flashes through their mind when they hear the words "Health Insurance". They are led to believe that it is a wonderful panacea, an insurance that insures for the people their *health*. The proponents imply that by some system of so-called insurance, by which the costs incident to sickness are distributed equally over the entire population, the people will be assured greater health than heretofore enjoyed. This they have very advisedly called "Health Insurance". I say advisedly because, originally, the system was called *sickness* insurance; but the word "sickness" is an ugly word. It lacks the enticing qualities of the word "health".

Again, in order to avoid certain objections and limitations implied in the word "sickness" they found it advisable to picture the obvious advantages of sickness preventive measures by arguing that under this system the patient would more readily visit a physician and thus place himself in expert hands in time to prevent more serious conditions, since a dozen visits would cost him no more than one. In other words, they argue, with medical services available to all under such a system, preventive measures would receive such a stimulus as to raise the people to a higher state of health than ever before.

This, if it were true, would surely be an ideal situation, but, health insurance by some other name will not smell so sweet.

This brings me to the title of my talk. "Why Is Health Insurance Not Health Insurance?"

In order to more clearly understand the subject, let us answer three questions.

I. What is meant by "health insurance"?
II. How is it operated?
III. What are the results?

The *first question* I have already answered.

THE OPERATION OF THE INSURANCE

The *second question* is divided into two main groups:

1. Voluntary.
II. Compulsory.

The first, voluntary insurance, I shall not discuss, for it opens up a field for discussion that alone would occupy more time than at our disposal.

The second group, compulsory health insurance, is the type that we at this moment are vitally concerned with; the public more so than the physician. By compulsory health insurance is meant some system of payment for, and distribution of medical services, established by law. The set-up is something like this:

THE FUNDS

A fund is established, made up from three sources,—

A. The employer
B. The employee.
C. The State.

Under the provisions of the law, the employee whose earnings are below a certain level has extracted from his wages, by the employer, a certain percentage of his wages. The *em-*

ployee is required to contribute a certain percentage of his pay-roll. The *employer* pays this into the treasury of the fund. The *State* also adds a certain percentage based on the wages of the employee. These three contributions provide the fund. This is the first reason for the statement that health insurance is not health insurance. It is *taxation*. The state levies on the man's wages, the employer, and the public. The funds the state supplies must of necessity be raised by taxation.

By such a scheme as this the employee is taxed in three ways.

First, directly through his wages;

Second, through the employer, for the employer must and will add the cost of his share of the insurance to his cost of production, which cost is naturally added to the cost to the consumer who is the employee, after all;

Third, the employee still must pay his share of the taxes levied by the state, either by direct taxation if he owns taxable property, or indirectly when he purchases anything taxable.

In the last analysis, the employee pays the whole bill. If he is unfortunate enough to need medical services, he gets some return for his taxes paid; but if he is not in need of such services, he pays anyhow for something he does not get. Thus, you see, "insurance" is not the word, but "taxation", and such taxation will be added to the already heavy burden of taxes borne by those least able to pay. It has been estimated that in America the tax would amount to from two to four billion dollars each year in the start. Incidentally, no one knows how high this tax would mount as time passes. So much for the source of payment under this system.

CHOICE OF PHYSICIAN

The next step is that the state designates certain physicians, who are willing to practice medicine under the prescribed conditions, from whom the employee may choose. These are the *insurance* doctors, and from this list the patient chooses his doctor, if the system permits a choice of physicians. In England such a choice is permitted. In Germany it is not. There the panel physician is assigned a designated list, or panel, and to him the patient goes. The patient nor physician has any choice as to who shall serve them, nor whom they shall serve. The physician may be paid on a fee basis (so much per visit), or on an annual lump sum basis of so much for each patient on his panel.

THE ENGLISH SYSTEM

Since the English system is recognized as the least objectionable of all the European systems thus far in operation, I shall give you a brief resumé of the details of that system, particularly since the present tendency is to use the British system as a criterion.

I. Who are insured under the acts?
   1. Compulsory contributors (ages 16 to 65).
      a. All manual workers.
      b. All non-manual workers receiving less than $1,250 annually.
   2. Voluntary contributors.
      This last is a limited group governed by special provisions, comprising only 3.2 per cent of all persons insured.

II. What are the weekly contributions and who makes them?
   1. Employer, nine cents.
   2. Male employee, nine cents.
   3. Female employee, eight cents.
   4. Government, approximately four and one-half cents per insured.

The expense of operation amounts to about 15 per cent of the total contribution, thus adding just that much more to the costs of medical service instead of lowering them.

III. What are medical benefits?
   1. All treatment within the bounds of general practice.
   2. Provisions of proper and sufficient medicines.
   3. Minor appliances and accessories.
   4. Free choice of doctor (qualified).
   5. Hospitalization is sometimes provided, although not specifically within the scope of the acts.

FINANCIAL BENEFITS

In addition, certain sickness benefits are provided which time will not permit to be considered, except to say that this feature has caused more trouble than any other feature, and if these benefits could be completely divorced from the service benefits, some, at least, of the objectionable features woud be eliminated; but it seems that to be consistant and sufficiently attractive it has been found almost impossible to separate the two.

A glance at the medical services allowed under these acts reveals a total absence of any provisions for real health measures; such as, periodic health examinations, adequate prenatal care, or post-natal care. A comparison of the maternal mortality statistics of England and America are quite enlightening. In England, during the last ten years, compared with America during the same period, the records show a wide margin of improvement in favor of America. The mortality rates and morbidity rates are all so much in favor of America that we should certainly hesitate to adopt any system that cannot show at least an equal record with our own.

This illustrates my second statement that health insurance is not health insurance, but sickness taxation. Proof is abundant that the health conditions of Europe are not as good as American conditions.

RESULTS OF EUROPEAN EXPERIMENTS

Now for the third question. What are the effects or results? In approaching the answer to this question let us ask another question. What are the benefits claimed for the system by its proponents? They claim principally:

1. A reduction in the average cost of medical services.
2. Adequate medical care for those previously unable to pay for it.
3. Adequate return for the doctor.
4. Improved public health.

To answer these questions, let us see what has happened in England, Germany and Austria. Since we as yet have no actual experience, we must depend on the experience of others and we are indeed blind or stupid if we fail to profit by the experience of others.

COSTS

1. Does the system reduce the costs of medical care?

A little study of the elaborate administrative bodies and machinery built up in these countries, adding from 15 to 27 per cent to the actual expenses for medical services, a glance at the steadily mounting costs due to malingering, etc., increased rates, etc., soon show one the fallacy of this claim.

ADEQUACY OF CARE

2. Adequate medical care for those previously unable to pay for it, is the serious concern of the people who are the ones who will suffer from a breakdown in the quality of medical service rendered. In the first place, if those who are so unfortunate as to come under the provisions of the acts, they do not have available the best of the profession when they need them most. They must be content with the services of the most mediocre. The best doctors will not enter the insurance service. The stultifying effect of the provisions and the necessity for maintaining as large a panel as possible in order to make a living, plus the constant interference of a third party in the patient-physician relationship, makes the service unattractive for the better doctors. Such mediocre service is more harmful in many instances than none at all.

Under these systems, the benefits are limited to the *employed,* and *occasionally to the dependents on the payment of additional assessments.*

No provision is made for unemployed nor indigent. They are as unfortunate as ever.

Furthermore, a *time limit* is set. In England, medical services and sickness benefits are for a period of 26 weeks only. The services available, as already intimated, include only those conditions that the family physician can take care of with the usual means at his command. As a rule, *no hospitalization* is provided for in England.

THE DOCTOR'S PAY

3. The third claim is adequate return for the doctor.

It is vital, in order to maintain the integrity of any service, that those who provide

that service receive a return that will insure for them a comfortable livelihood and sufficient incentive to improve the quality of his service.

Without burdening you with a discussion of this phase of the problem, intimately connected as it is with the success or failure of any system, I shall pass on with a plain statement of fact that the financial condition of the physician is not sufficiently improved to repay him, or the public, for the tremendous losses to medical progress and social improvement suffered under these systems.

EFFECT ON PUBLIC HEALTH

4. I have already shown how public health is not improved. It may be that in some of the countries their present health state is better than before the advent of the system. This would be expected under any system, because of the advances medical science has made, throughout the world, particularly in the field of broad public health measures along the lines of sanitation, housing, contagious disease control, etc. But to reiterate, a comparison of the advances made in America without compulsory insurance and in those countries having insurance, shows much faster progress here than abroad. This is not a loose statement but can easily be substantiated.

To summarize, then, compulsory health insurance is not health insurance, because:

1. It is taxation.
2. It does not insure health.
3. It provides, at increased cost, funds to pay for ordinary illnesses that need no special consideration on the part of the employed worker.
4. It does not provide for the indigent nor unemployed when sick.
5. It makes all pay a high price for something that only a percentage will need.

Notwithstanding the soundness of our position, and notwithstanding the fact that thus far many of the proposals for social security are really only attempts at palliation of states of poverty brought about by economic faults and will no more correct basic evils than the amputation of gangrenous toes will cure the underlying diabetes,—notwithstanding all this, we, the physicians of this country, find ourselves in a rather uncomfortable position and it behooves us to take stock of the situation.

THE TREATMENT OF BURNS

By SPENCER T. SNEDECOR, M.D., F.A.C.S., Hackensack, N. J.

Outline of a lecture given in the Hackensack Hospital on April 17, 1935, during the Post-Graduate Course of the Bergen County Medical Society

The purpose of this article is to inform the general practitioner of the remarkable advances which have taken place in the treatment of burns during the past decade.

To Dr. Edward C. Davidson, of Detroit, must go the credit for the major progress in the therapy of burns. By his discovery of the beneficial effects of tanning the raw surface of burned skin, he has revolutionized all our previous conceptions of the care of burns.

Ointments and oils have little or no place, we believe, in the modern treatment of a burn of the second or third degree; and a burn which a doctor sees is usually of the second degree or worse. Emphasis is given to this statement because there is still a widespread use of ointment treatment even though it has been discarded in all the clinics which are reporting improved results.

GENERAL EFFECTS OF EXTENSIVE BURNS

1. *Shock* is the primary and immediate condition of serious danger.

   Its causes are:

   A. Exposure of and injury to sensory nerves.

   B. Loss of body fluids, with a rapid increase in blood concentration.

   C. Loss of body heat.

2. *Toxemia* is a secondary danger, coming after 24 to 48 hours, and is the result of the absorption of toxins in burned tissue. The exact mechanism, and specific poisons are still unknown.
3. *Infection* is a tertiary danger, but very serious. It may be caused by bacterial contamination on and in burned skin, and by dressings. The organism is usually a streptococcus.

SPECIFIC EFFECTS

1. The concentration of blood hemoglobin goes up immediately,—
   A. When the hemoglobin is 125, the patient is in danger;
   B. When the hemoglobin is 140, his condition is critical.
2. The red blood cell count is increased to 7 or 8 million per c.m.m.
3. Blood chlorides are lowered from a normal of 450 milligrams per liter, to 300. This affects tissue osmosis.
4. The leucocyte count goes up to from 15,000 to 30,000 per c.m.m.
5. The blood NPN and blood sugar are usually raised somewhat, but this is of little significance.
6. Oliguria, albuminuria, and hemoglobinuria are late kidney manifestations.

THE IDEAL TREATMENT

The treatment is based on these principles:
To care for the immediate shock.
To prevent toxemia, and infection.
To secure early healing with minimum scars and contractures.

TREATMENT OF SHOCK

A. Morphine, grains one-quarter to one grain, in order to relieve pain.
B. Stimulants,—hot drinks; hot enemas; elevation of the foot of the bed,—infusion of 10 per cent glucose.
C. Prevent heat loss by keeping the burned area, or even the whole body, under a tent at 90° to 100° F.
D. Restore fluids and chlorides to the blood. Hypodermoclysis, or infusion of 1000 c.c. of glucose and saline every eight hours during the first day.

A practical rule is one quart fluid per 25 pounds body weight daily for adults,—more for children.

Transfusions are useful to combat shock, loss of blood plasma, and toxemia. Do frequent blood counts in order to see when they are necessary.

TREATMENT OF THE LOCAL BURNED AREA

A. Careful cleansing, with benzine, saline, soap or ether.
B. Remove oil or grease. The saline bath is sometimes useful.
C. All blebs are to be removed.
D. Give an anesthetic if necessary to allow thorough skin cleansing if the general condition permits.
E. If an acid or an alkali is the cause of a burn, it is much better to dilute the chemical with water than to try to neutralize it with a specific antidote.
F. Apply tannic acid at once. Use an aqueous 5 per cent solution, and spray it on the burned area every 15 minutes.

   Wet dressings, or a bath of tannic acid solution, may be used in place of the spray.

G. Other local treatments may be used, such as:

1. Gentian violet in one per cent solution, used in the same way as the tannic acid makes a thinner, more pliable eschar, and is more antiseptic.

2. Normal saline, or soda bicarbonate 10 per cent. Begin with continuous baths; after 3 or 4 days alternate with open air treatment.

AFTER-CARE

1. Trim the coagulum away as fast as it loosens. Do not soak the coagulum off. Paint the edges of the area daily with one per cent gentian violet solution.

2. Open and trim any pouches or bulges in a coagulum which may cover a pocket of serum. Rising temperature usually means such areas of absorption.

3. The open air treatment heated cradle or tent is best after the coagulum is removed from third degree burns. Second degree burns heal under the coagulum.

4. If saline has been used give increasing daily exposures to open air.

5. Watch elimination; force fluids; check the blood count and blood chlorides frequently.

6. Do a skin graft as soon as an area of clean granulation is exposed. Do not wait too long for the field to become sterile. A normal saline dressing used for 24 to 48 hours is usually a sufficient preparation. The operation does not require a skilled surgeon.

A. Pinch or Riverdin grafts are most useful. In chronically infected areas, such as the buttock, they should be buried deep in the granulations.

B. Thirsch or thin slice grafts are preferable for the face, or for large areas. Occasionally split grafts are useful.

C. Sieve or pedicle grafts of full thickness are usually not indicated for primary grafts; but they may be best for secondary plastic work.

Be sure to bind the grafts down with parafin mesh or single thickness gauze. Use a dry dressing. Immobilize the area. A plaster cast is sometimes very helpful. Do not dress the grafted area for at least five days.—preferably ten days.

7. *Prevent contractures.*

Burns involving joint areas, such as the knee, ankle, shoulder, and elbow, make active exercise and protective apparatus necessary in order to preserve the flexibility of the skin.

At the shoulder, abduction is needed. At the elbow or knee, traction should be applied to prevent flexion contracture.

8. *Physical therapy,* such as oil massage, sine wave exercise, and active and passive exercise, is very helpful to overcome residual scar tissue, adhesions, and contractures, especially on the face and hands.

SUMMARY

The advantages of the tannic acid treatment are worthy of a special review.

A. Saves lives. The mortality for serious burns has been reduced from 32 to 36 per cent to 12 per cent.

B. Relieves pain, and makes the patient comfortable.

C. Lessens toxemia and infection.

D. Hastens recovery. The time of hospitalization has been reduced by one-third.

E. It produces softer scars and fewer contractures than any other method.

As a final recapitulation we should place particular emphasis on thorough cleansing, a full tannic acid eschar, and early grafting.

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TRAUMATIC INTRACRANIAL HEMORRHAGE

By THOMAS S. P. FITCH, M.D., Plainfield, N. J.

Read before the Hunterdon County Medical Society, April 23, 1935

Traumatic intracranial hemorrhage includes various forms of hemorrhage which would require much more time than we have at our disposal to discuss in detail. There are several important groups which can be distinguished clinically and which require special treatment. We used to hear and read much of fractured skulls, but we soon learned that patients did not die of fractured skulls, per se. People with fractured skulls died as the result of the brain damage beneath. The presence of a fracture, unless compounded or depressed merely indicates that the force of the impact must have been severe and that brain damage is likely to be present.

CEREBRAL CONCUSSION

In the majority of cases, the brain damage in head injuries is *hemorrhagic* in type. The mildest type of brain injury is simple *concussion,* which often presents no demonstrable pathology and whose mechanics can still be given ample speculation.

CEREBRAL CONTUSION

From simple concussion, the next form of brain injury is called severe concussion, or

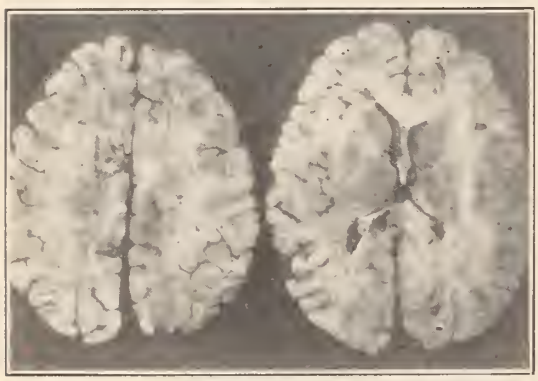


Fig. 1—Cross Section of Brain. Cerebral Contusion.

brain contusion which are often associated. Here we find small minute multiple scattered hemorrhages which may occur in any location of the brain. Fig. 1 demonstrates the gross section of a brain from such a case. These scattered hemorrhages as a rule cause the patient to appear immediately in a state of *traumatic stupor.* They then pass through a stage of *cerebral irritation* in which they are dis-



Fig. 2—Acute Hemorrhagic Encephalitis.

oriented, irritable, and lie curled up in bed. They complain of headache, and photophobia is apparent. They dislike being disturbed for examination, and resist the examiner. There is a similarity of the gross appearance of a cross section of the contused brain to that of acute hemorrhagic encephalitis. (Fig. 2.) The multiple scattered hemorrhages are also present and the clinical reaction is similar.

The treatment of these cases is *conservative,* that is to say, not surgical and many different and divergent opinions have been expressed by numerous authorities. The subject offers much controversy but we no longer operate for cerebral contusion and edema for we have learned that operation offers no help. These cases can best be controlled by dehydration, fluid regulation, and spinal punctures following the preliminary shock measures.

LOCALIZED CEREBRAL HEMORRHAGE

A more massive and localized cerebral hemorrhage (Fig. 3) causes a patient to react in a similar way as the hemorrhage of an apoplectic patient, appearing immediately in deep coma and often presenting a hemiplegia. If these more

extensive intracerebral hemorrhages should communicate with the ventricular system, we naturally have what is known as *intraventricular hemorrhage*. This is manifested by

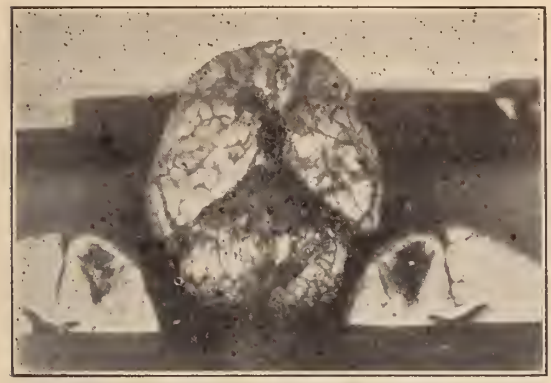


Fig. 3—Multiple Traumatic Hemorrhages.

deep coma, excessive perspiration, often bilateral spastic extremities, contracted pupils, and a rapid rise of temperature ending in death. A ventricular puncture and withdrawal of the bloody fluid might be attempted. A typical picture shows the 3rd and 4th ventricles filled

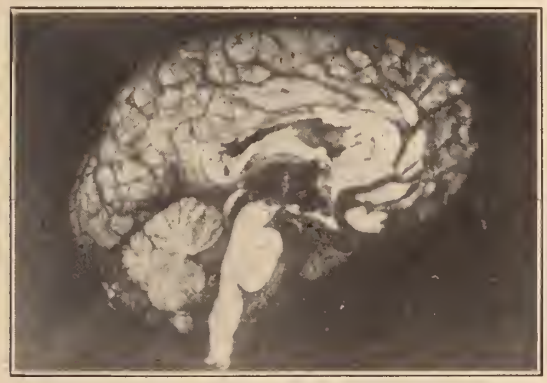


Fig. 4—Ventricular Hemorrhage.

with blood (Fig. 4), as well as a massive collection of blood in the basal cisterns, externally. Blood may also be seen in the subarachnoid space over the cerebral cortex.

This suggests another hemorrhagic entity which we may call *traumatic subarachnoid hemorrhage*. The blood is in the subarachnoid space escaping from a vessel near the surface, and should be considered in a similar way to spontaneous subarachnoid hemorrhage. It is often associated with a rise of temperature in the head injury cases, and is frequently accompanied by a stiff neck and other meningeal signs. These patients are likely to be considered as developing meningitis. A diagnostic spinal puncture soon differentiates these two conditions by the presence or absence of blood. These patients respond beautifully in the majority of cases to repeated spinal punctures and spinal drainage. Judgment must be used not to remove fluid in the presence of high intracranial pressure, or if the blood is excessive. Caution and deliberate action in such cases is necessary. With the removal of the irritating blood, the patients are soon relieved of their headache, the temperature returns to normal, and the meningeal signs disappear.

EXTRA-CEREBRAL HEMORRHAGES

In the entire field of serious head injuries, the recognition and treatment of subdural and epidural hemorrhages offers the greatest responsibility to the attending physician. The physician who recognizes this important group and proceeds with the proper surgical treatment will have a great deal of satisfaction. These cases are often dramatic in their rapid return to consciousness and it is remarkable how these critically ill patients presenting themselves with excruciating headache and perhaps convulsions or hemi-paresis, are restored to normal.

Subdural and epidural hemorrhages will eventually cause the death of the patient if not treated surgically. Delayed diagnosis made at autopsy is a real tragedy, and we can recall such cases with much chagrin. Many of these cases are lost because the condition is not looked for.

An extension subdural hemorrhage (Fig. 5) was found in a specimen which was taken at the autopsy of the brain of a middle-aged gentleman who went to a chiropractor in Elizabeth. During the adjustment of a cervical vertebra, he was given a severe thrust on the back of his neck. He soon lost consciousness, and was kept in the office for about an hour until he regained his faculties. He complained of a severe headache, but was placed in a taxi and sent to his home in Roselle. That afternoon he lapsed again into a coma and a reg-

ular practitioner was called who sent him immediately to Muhlenberg Hospital by ambulance. He died very soon after his admission, and the autopsy revealed a massive hemorrhage in the subdural space which shows no lamellation.

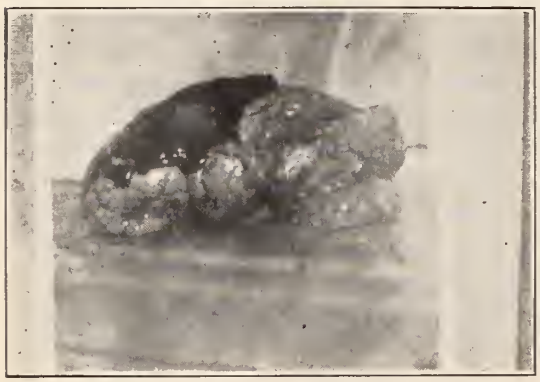


Fig. 5—Subdural Hemorrhage.

This case illustrates several important points. First it shows that a trivial injury may be the cause of a subdural hemorrhage. Second, it shows that the force had been applied in a posterior-anterior direction of the skull. This is found to be a very common factor. Third, it presents a typical lucid interval which is highly characteristic. Fourth, it illustrates the rapid death which may follow a subdural hemorrhage.

Subdural hemorrhage are most often produced by a rupture of an unsupported cerebral vein as it leaves the cortex of the brain to enter one of the venous sinuses of the dura, particularly the longitudinal sinus in the region of the vertex. This explains why a blow on the occiput or on the frontal region is most apt to produce these lesions. It is also important to determine whether the patient's head was stationary or in motion at the time of the impact. It is more apt to occur when the head is the moving object and is suddenly stopped by an impact against an immovable object. In such cases the brain is in motion and the skull is suddenly retarded, causing the brain to slide in a sagital direction and thus tear one of the small emissary veins. If the bleeding is arterial in origin, and especially if it is accompanied by a laceration of the brain, the coma is sudden in onset and the case progresses rapidly to a fatal termination. If the symptoms progress more slowly, we can then assume that the origin of the hematoma is venous.

Dr. B. M. Vance[1] from his invaluable experiences as assistant Medical Examiner in the City of New York, reports that subdural hemorrhage occurred in 26 per cent of the deaths in a series of 507 cases of fractured skull. In that number, he found a subdural hematoma of sufficient size to produce increased intracranial pressure. He records the fractures in these cases to be most frequently in the posterior portion of the skull and in numerous instances, there was a contracoup brain injury causing the hemorrhage. He states that subdural hemorrhage below the tentorium is rare and often insignificant. He calls attention to the relation of contracoup injuries and the head being in motion at the moment of impact.

Timothy Leary[2] explains the mechanics of brain compression in subdural hematoma by the neo-membrane acting as a semi-permeable membrane. The absorption of fluid occurs through osmosis caused by the blood protein molecules breaking up into smaller molecules within the membrane. This intermittent swelling causes compression of the brain. Repeated hemorrhages into the original hematoma by large, poorly developed blood vessels in the membrane wall may occur. Donald Munro[3] shows experimentally that by dialysis, fluid may increase the capacity of the membrane from 39 to 103 per cent.

Epidural hemorrhage has many points of similarity with subdural hemorrhage as far as the symptomatoligy is concerned. We again quote Dr. Vance who reports that epidural hemorrhage is rare in children and most frequent between 30 and 40 years of age. The reason for this is that the middle meningeal artery has not become canalized in the skull in early youth. Of epidural hemorrhage which constitutes about 12 per cent of the deaths from fractured skulls, the middle meningeal artery was most frequently ruptured, but the lateral sinus accounted for some.

CASES OF EPIDURAL HEMORRHAGE

Case 1

G. C. V., aged 20 years, a parachute jumper of the U. S. Navy was admitted to Middlesex Hospital, New Brunswick, June 13th, 1933. He had been riding his motorcycle from Pensacola, Florida, to the Brooklyn Navy Yard when he was upset and hurled through the air head foremost against a tree. He was dazed, but had recovered consciousness on admission to the Hospital and complained of a severe headache. An x-ray (Fig. 6) of his skull taken by Dr. Avery with a portable ma-



Fig. 6—Case No. 1. Fracture of Skull Crossing Longitudinal Sinus.

chine, showed a well marked fracture of the vertex.

Two days later, the patient was very drowsy, but could be aroused and was coöperative. He complained of an excruciating headache in the frontal region and pain back of both eyes. Examination showed bilateral choking of his optic discs, contracted but equal and active pupils. The left abdominal reflex was easily exhausted, the right remaining active. There was a definite weakness of both lower extremities and positive bilateral Babinski signs. His temperature was 99, pulse 52, repirations 14. The pulse was suggestive of intracranial pressure.

A spinal puncture revealed the amazing pressure of 50 mm. mercury, and the fluid was clear. The needle was withdrawn immediately. It is very unusual to have such a high pressure with a conscious patient in acute head injury. He was taken to the operating room and under local novocaine anesthesia a horse-shoe incision was made over the vertex of his skull in the depressed fracture area. The skin flap was reflected and the fracture line exposed with its depression. An osteoplastic flap was made across the mid-line over the vertex. On reflecting the bone a large extradural blood clot was evacuated from both sides. The patient stated that there was instant relief of his headache when the bone flap was elevated. He laughed and joked with us through the remainder of the operation. Large firm clots were scooped from both sides. The bone flap was returned and two rubber tissue drains inserted. He was typed and given a blood transfusion.

Following the operation the weakness in his extremities improved and his complaint of headache disappeared. His operative wound healed by primary union and ten days after operation he was discharged to the Naval Hospital in Brooklyn in good condition.

Case 2

A. J., aged 35 years, was admitted to Muhlenberg Hospital February 11th, 1933, from injuries received in an automobile accident. She was knocked unconscious, but regained consciousness on admission to the hispital and was complaining of severe right-sided headache. She became stuporous, but could be aroused eight hours later.

Her eyes showed a conjugate deviation toward the right. A slight left facial asymmetry was present. The left abdominal reflexes were absent and the deep reflexes increased on the left side. Her spinal fluid pressure was 28 mm. mercury, and bloody fluid was present. There was a weakness of the grip in the left hand. No x-rays had been taken and we did not delay operation at that hour to have them taken.

An opening was made in the right side of her skull and through the first drill hole in the bone, a black clot exuded. On opening further an extensive extradural clot was evacuated. The foramen spinosum was plugged to control middle meningeal bleeding. She made a complete recovery from all her neurological signs. Her temperature, pulse and respirations were practically normal throughout. Follow-up examinations show her to be in perfect health to the present time.

Case 3

E. M., aged 32 years, was in an automobile accident, admitted to Muhlenberg Hospital, November 28th, 1930. He was unconscious, but recovered consciousness in 24 hours. He presented a dilated fixed pupil on the left side. His reflexes were all sluggish. Abdominal and Babinski signs absent. He developed an engorgement of his retinal vessels which ended in a frank papilledema. The x-ray showed a fracture crossing the left middle meningeal artery. His spinal fluid pressure was 20 mm. mercury, and blood was present.

On regaining consciousness, he was irrational and highly irritable for several days, resembling a post-traumatic psychosis, frequently running up and down the hospital corridors in terror. His spinal fluid pressure showed no tendency to come down under spinal puncture and dehydration treatment, so it was decided to operate. A large extradural blood clot was removed from the left temporal fossa and the middle meningeal artery was plugged at the foramen spinosum.

This man returned from the operating room an entirely different personality. He became quiet, docile and cheerful, and made a good immediate post-operative recovery. Unfortunately he became involved in a series of difficult court trials over the litigation of his accident and more than a year later, February, 1932, he showed a paralysis of the left side of his body. Examination showed no neurological signs of an organic lesion. The

paralysis appeared on the same side of the body as his head injury. In order to be certain that a hemorrhage had not occurred on the opposite side, he was admitted again to Muhlenberg Hospital for encephalography. His encephalogram showed no



Fig. 7—Case No. 3. Encephalogram. Ventricles in mid line.

deviation of the ventricles. (Fig. 7.) His spinal fluid pressure was found to be normal. The importance of this procedure in determining whether the symptoms in this case were organic can be readily seen. The paralysis disappeared suddenly.

Case 4

E. L., aged 32 years, admitted to Muhlenberg Hospital, May 18th, 1931, referred by Dr. Schenk.



Fig. 8—Case No. 4. Encephalogram. Ventricular shift. Extradural hemorrhage.

He had been riding a motorcycle two days before when he was involved in an accident in which he was dazed from a head injury. He rode his motorcycle home, and on his arrival complained of severe headache and became unconscious. He recovered from his coma at intervals in the next two days but each time returned to the unconscious state. The x-ray of his skull on admission showed a fracture in the right side crossing the middle meningeal blood vessel groove. This boy had no abnormal neurological signs other than the intermittent coma. The spinal fluid pressure was increased to 30 mm. mercury, and bloody fluid was present. Because of the paucity of focal signs, an encephalogram was made (Fig. 8), which shows a displacement of the ventricles toward the left side with a partial obliteration of the anterior horn of the right lateral ventricle. A temporal opening was made in his skull and a large extradural blood clot was removed from the right frontal region. He made a good post-operative recovery with normal temperature and pulse and was discharged eleven days after operation. He has remained in excellent health to the present time.

Case 5

M. R., aged 20 years, entered Muhlenberg Hospital February 14th, 1933. She had been injured in an automobile accident and brought to the Hospital in a stuporous condition. She was drowsy but could be aroused. She showed no focal neurological signs. Her spinal fluid pressure was 18 mm. mercury, and bloody fluid was present. An

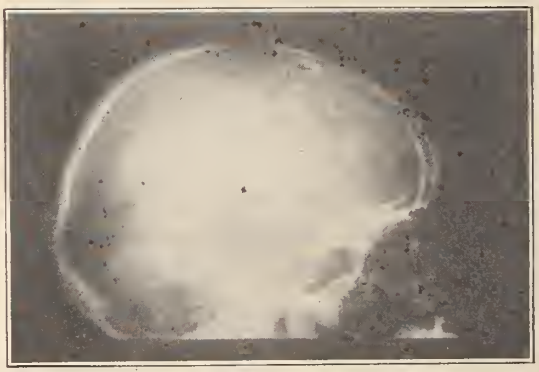


Fig. 9—Case No. 5. Fracture crossing middle meningeal artery.

x-ray (Fig. 9) showed a vertical fracture in the left side of her skull extending from the vertex to the base. Dehydration and spinal punctures failed to reduce her pressure, and three days later she was still complaining of severe headache in the right parietal region. An encephalogram (Fig. 10) was made and showed an absence of air over the left hemisphere with a shifting of the ventricles toward the right side.

She was taken to the operating room and a left temporal opening made in her skull. An extradural blood clot was found in the frontal region and evacuated. The middle meningeal artery was clipped by silver clip near the foramen spinosum. She made an uneventful recovery and has remained perfectly well until the present time.



Fig. 10—Case No. 5. Encephalogram. Ventricular shift. Extradural hemorrhage.

Case 6

C. Y., was referred by Dr. Boyer of Clinton from the New Jersey Reformatory. He was admitted to Skillman Infirmary March 7th, 1931. He had fallen from a truck and had made a good immediate recovery from what seemed to be a trivial head injury. A few weeks later he complained of severe headache and appeared apathetic. His eye grounds showed choked discs, and his visual fields demonstrated a homonymous hemianopsia on the right side. The right temporal region of his skull was opened and an epidural clot of blood evacuated. He was discharged 16 days later in good condition. The point well exemplified by this boy was the importance of taking visual fields to localize the blood clot.(4)

SUBDURAL HEMORRHAGE

Case 7

J. D., was referred by Dr. Hegeman. He had been injured on August 16th, 1932. While walking on the road, he was struck by a car. He was unconscious a few minutes, and was not oriented on admission to Somerset Hospital. Examination showed a swollen area in the occipital region. X-ray showed no fracture of the skull. He was irrational in the early part of his stay at the hospital, getting out of bed and appearing to be in a dazed condition. He had bloody spinal fluid and complained of headache.

On September 1st, 1932, he was discharged mentally clear. On his return home, he was somewhat irritable and showed clumsiness of the left side of his body. October 16th, 1932, he had an attack of headache and vertigo with projectile vomiting during the night. The next morning he had a complete left-sided hemiplegia, the arm more involved than the leg and a drooping of the left side of the mouth. The left pupil was larger than the right.

On October 20th, the patient had a convulsion and was unconscious for one and one-half hours. My examination on October 20th showed a left spastic hemiplegia with no voluntary motion on the left side of the body. A left central facial weakness and conjugate deviation of the eyes to the left and deviation of the tongue to the left. There were cortical sensory changes on the left side of the body. He had a Jacksonian convulsion involving the left side. Spinal fluid pressure was 18 mm mercury, and an encephalography was performed, showing a ventricular deformity (Fig 11). A subdural hemorrhage in the right frontoparietal region was diagnosed.



Fig. 11—Case No. 7. Encephalogram. Ventricular shift. Subdural hemorrhage.

A right fronto-parietal osteoplastic flap was turned down and on reflecting the dura, a large hematoma with a thick capsule was found to be present over the right cerebral hemisphere. The greatest volume of the clot appeared to be in the frontal region. The clot was evacuated and the membrane removed. The patient made a good post-operative recovery. Power returned to the upper and lower extremities and the facial paresis disappeared.

Case 8

I. H., aged 72 years, referred by Dr. Craig and Dr. Schwartz, was admitted to Somerset Hospital November 23rd, 1934, in an unconscious state which had come on ten hours previously. His wife stated that he had complained of severe headache for four weeks and had shown mental changes characterized by forgetfulness. He had been irritable and emotionally unstable. The previous two weeks, his left hand and leg had been weak and he walked with a limp. Stupor and coma had come on gradually.

The patient had been in two automobile accidents three months before while visiting in California. In the first he suffered no injury other than a mental shock and trivial shoulder injury. In the second he was unconscious for about ten minutes and remained in a hospital only one day. He continued his tour of California and returned

to his home in Hunterdon County. On admission to Somerset Hospital he was in deep coma from which he could not be aroused.

The patient had a left-sided hemiplegia. The question arose as to whether this was ordinary hemiplegia from cerebral thrombosis, or a subdural hematoma. Spinal puncture showed the pressure to be 20 mm mercury, and the subdural hematoma was decided to be most likely. His skull was opened on the right side and a large blood clot with a dense capsule was found. A large amount of greenish-red degenerated blood was removed. He regained consciousness on the operating table as the blood was evacuated and became rational enough to coöperate with us until the operation was finished under local anesthesia. The next day he was bright, rational, oriented and coöperative. His hemiplegia gradually cleared up and he is now quite well and driving his own car.

Case 9

G. T., aged 34 years, admitted to Muhlenberg Hospital November 26th, 1934, referred by Dr. Steffens. She had stepped from an automobile and was struck by another passing car. She was knocked unconscious and was brought to the Hospital. On admission she had a severe convulsion which appeared Jacksonian in type involving the right side of the body. The right abdominal reflexes were depressed. The deep reflexes on the right side were increased and a positive Babinski sign was prsent on the right side. There was ecchymosis of the left eye with conjunctival hemorrhage and bleeding from the nose. With the patient in coma, showing localized convulsion and pyramidal tract signs on the right, an immediate operation was performed. A left temporal opening was made in the skull and an extensive subdural hemorrhage evacuated. She made an excellent post-operative recovery and was discharged ten days later, and has resumed her duties as housewife.

Case 10

I. C., aged 55 years, admitted to Muhlenberg Hospital July 4th, 1935. This patient had been complaining of severe headache following a trivial injury three weeks before, when she had struck her head on the roof of a car. She gradually became irritable and finally stuporous, and on admission to the hospital showed a right-sided hemiplegia. She could not be aroused and her spinal fluid pressure measured 20 mm. mercury, with clear fluid present. Her pulse was 140 and temperature 104.

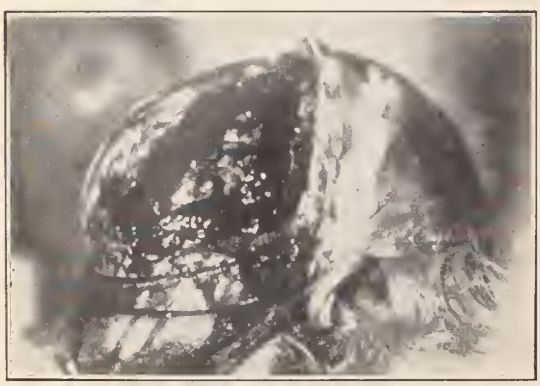


Fig. 12—Case No. 10. Dura Reflected to Show Subdural Hemorrhage.

A diagnosis of subdural hematoma was made, but her condition was too critical to operate. Dehydration was attempted and everything put in readiness for operation if she rallied. She died one hour later.

The autopsy showed a massive subdural blood clot on the right side (Fig. 12), which was the same side of the body as her hemiplegia. This illustrates a case of homolateral pyramidal tract signs which is not rare in subdural hematoma. If the diagnosis is made and no clot found in the contralateral side of the brain, it is well to explore the homolateral side.

COMMENT

In the extradural and subdural hemorrhage, probably the most constant focal sign is a dilated fixed pupil.

Extremely suggestive signs are: 1. the unilateral absence of abdominal and cremasteric reflexes with positive Babinski or Oppenheim.

2. A central facial weakness in the presence of choked discs.

3. Increased spinal fluid pressure which does not improve under dehydration measures.

There is a characteristic type of respiration which resembles sound sleep. The expiratory phase is exaggerated.

The coma is apt to be intermittent, and the patients are mentally dull and drowsy in the lucid intervals.

The following points which were of value in diagnosis are:

1. Lucid interval, with perhaps a trivial injury.
2. A detailed history of the circumstances of the accident.
3. Headache, drowsiness, and coma.
4. The focal signs.
5. Persistent increased intracranial pressure.
6. The value of encephalography as a final court of decision in obscure cases.

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EXTERNAL FRONTO-ETHMO-SPHENOID OPERATION

By Oram R. Kline, M.D., Camden, N. J.

Read before the Section on Eye, Ear, Nose and Throat at the 169th Annual Meeting of The Medical Society of New Jersey, in Atlantic City, May 2, 1935

Adequate treatment of acute fulminating and intractable chronic suppuration of the frontal and ethmoid group of sinuses often presents a difficult and distressing problem.

In addition to the immediate symptoms of pain, discharge, nasal obstruction and impending orbital involvement, we have constantly before us the dreaded complications of progressive osteomyelitis and intracranial suppuration. Responsibility to our patient demands that we decide when the path of conservative treatment is fraught with greater danger than that of radical operative interference.

The indications for surgical opening of the frontal sinus vary with the operator; and furthermore there is much controversy as to the type of operation that should be employed. It is not the purpose of this paper to set forth the advantages of any one type of operation over others; but rather to give a brief summary of the development of recognized external operative procedures upon the ethmo-frontal group of sinuses followed by a more detailed description of the orbital approach. Finally, there will be a presentation of a case operated upon more than two years ago by this method on both sides.

Previous to the last decade of the nineteenth century, practically no radical surgery was being done upon the frontal sinus, operative procedures consisting chiefly of the simple trephine enlarged sufficiently to permit irrigation with antiseptic solutions and the application of caustics. The result was so unsatisfactory that in the year 1887 the Berlin Medical Congress concurred in the opinion that the frontal sinus should be opened only when rupture of the cavity, displacement of the bulb, and pressure on the brain existed. Within a few years following this dictum various operators began to report more radical methods of managing infection in this area. In 1890 Nebinger and Praun through an opening in the anterior wall removed the lining mucous membrane, enlarged the nasofrontal duct, and closed the wound with external drainage. Luc and Ogston added curettement of the anterior ethmoid cells and drainage through the nose, the external wound being completely closed. Kuhnt in 1895 removed the entire anterior wall of the frontal including that of the upper part of the nasofrontal canal, removed the mucosa, and employed external drainage. The nasofrontal duct was not enlarged as the desired result is complete obliteration of the sinus.

During this period osteoplastic resection of the anterior wall was also being developed, Golovine reporting three cases in 1897. Jansen in 1893 thought a better method would be to remove the floor or inferior wall of the sinus leaving the anterior intact. Through a curved incision below and parallel to the eyebrow from the external orbital edge to the root of the nose he removed the entire floor of the frontal sinus and then attempted to remove all of the lining mucous membrane. Finally he curetted the ethmoidal labyrinth, closed the wound externally and drained through the nose with gauze strips. Ritter attempted to gain better access to the frontal cavity by removing the transition area of the orbital into the anterior wall. In 1898 Riedel removed both the anterior and inferior walls of the frontal together with the anterior ethmoid cells. He drained the wound both externally and through the nose. This operation causes a marked deformity but gives good curative result in cases that can be handled by no other method. Killian in 1902 removed both the anterior and inferior walls but retained the orbital ridge, thus giving a much better cosmetic result than the Riedel operation. The ethmoidal cells and the sphenoid may be opened if desired.

The various methods of managing infection in this area that were brought out in this brief period have since been modified and developed by many capable surgeons, but time does not permit a review of this work. It may be said,

however, that most of the external operations performed today are included under one of the following three headings: (1) A Modified Killian; (2) the Skillern, in which the entire anterior wall and lining mucosa of the frontal is removed followed by enlargement of the nasofrontal duct. A large calibre rubber tube is then passed down through the nasofrontal duct to the floor of the nose for drainage and the external wound completely closed. Any indicated surgery upon the ethmoidal cells and sphenoid is done intransally. (3) A Modified Jansen.

The orbital approach, first described by Jansen in 1893, was modified and developed in America by Robert Lynch, who in 1921 reported 100 per cent satisfactory results in a series of fifteen cases. His enthusiasm stimulated renewed interest in this method. Sewall in 1926 reported a technic in which he shortened the incision, tied the ethmoid artery, and used local anesthesia. Ferris Smith a few years later introduced several instruments that facilitated the operation and added the Thiersch skin graft to maintain a proper drainage duct for the unobliterated portion of the frontal sinus. Seiffert in 1924 had reported the use of transplanted skin from the thigh to maintain the patency of the nasal frontal duct after the Killian operation. In 1934 Smith reported having operated on more than five hundred patients by this method. There were five deaths, all occurring in the first group of one hundred, but he felt that only two of these could be considered as caused by the operation. He states that the clinical results are, in general, satisfactory.

The patient I am presenting had been subject to asthmatic attacks for many years which had progressively increased in frequency and severity. For several months immediately preceding the operations she was never free from asthmatic symptoms and required almost daily injections of adrenalin. Both nares presented polyps and hyperplastic mucosa bathed in muco-pus and she gave the history of recurrent frontal headaches which were worse and more frequent on the left side. Previous intranasal operations including submucous resection of the septum, removal of polyps and a partial ethmoidectomy on the left side gave relief from nasal obstruction but the asthma had persisted.

On March 23, 1933, an external radical operation was performed upon the ethmoid labyrinth, sphenoid and frontal sinuses of the left side. Three weeks later the same procedure was carried out on the right side. The following technic was employed, which is essentially that advocated by Ferris Smith:

One allonal tablet is given the evening before operation. Two tablets at 10 a. m., and a hypodermic injection of morphine sulphate, gr. 1/6, and scopolamine hydrochloride, gr. 1/150, at 2 p. m., one hour before operation. The face is painted with 3 per cent iodine followed by alcohol. The side of the nose to be operated upon is packed with cotton strips wrung out of a solution of epinephrine hydrochloride (1:2000) containing 10 per cent cocaine. Two per cent procaine hydrochloride solution containing 20 minims of epinephrine hydrochloride to the ounce is used to infiltrate the field of operation, first the skin and then the deep tissues. Fluid should not be injected to the point where landmarks are obscure. The eyelids are closed by a horsehair suture to prevent injury to the cornea.

The incision is an arc about 2 cm. in length beginning just below the eyebrow and passing about 1 cm. mesial to the inner canthus of the eye. It is carried down to the bone and the bleeding points ligated. The periosteum is elevated on the external side of the incision exposing the ligaments of the lacrimal sac, which are incised and the sac turned outward and downward. The periorbital periosteum is then elevated from the entire lamina papyracea and the floor of the frontal sinus, particular care being taken not to tear the periosteum along the fronto-ethmoid suture in the region of the attachment of the pulley of the superior oblique muscle. As the elevation progresses along the inner orbital wall, a point is noted where the periosteum is firmly attached. This is the site of the ethmoid foramen through which pass the ethmoidal vessels and nerve. The periosteum is elevated above, below and behind this point. A self-retaining retractor with a slotted blade on the external side is introduced into the wound so that the periosteum, still attached to the ethmoid foramen, passes through the slot. As the retractor is spread, the orbital contents are displaced laterally and the periosteum attached to the ethmoid foramen is placed on a tension and is, in fact, a sheath enclosing the ethmoid vessels and nerve. Cotton-wound applicators wrung out of 10 per cent cocaine solution are applied above and below this sheath to anesthetize the ethmoid nerve and it is then ligated and cut through at the bony foramen. The mesial orbital wall is now perforated in the region of the lacrimal fossa and punch forceps introduced to enlarge the opening. The lamina papyracea is removed with the exception of a wall about ¼ inch high along the orbital floor, if the condition of the bone permits. All the ethmoid cells and the middle turbinate are now removed with punch forceps under direct vision, the punch being used both through the nose and through the incision. The ostium of the sphenoid is now enlarged to admit punch forceps and the anterior wall is removed. Before the lower portion of the anterior wall is removed, it is necessary to separate the mucoperiosteum as it contains the sphenopalatine vessels. Smith here advises liga-

tion of the sphenopalatine vessels near the nasal septum and then removes the floor of the sphenoid placing a flap of pharayngeal mucoperiosteum against the posterior wall of the sphenoid after the sinus mucosa has been removed, a procedure that was not carried out in this case. The frontal sinus is now entered through the floor and the entire floor removed with punch forceps and rongeurs. All mucous membrane is removed from the sinuses operated upon by the use of small gauze balls soaked in a solution of 5 per cent trinitrophenol in 35 per cent acetone. The frontal sinus is packed with gauze saturated with this solution for a few minutes and the lining membrane then very easily peels off the bone. Inspection of the frontal cavity with a laryngeal mirror should reveal clean bony walls A satisfactory result of the frontal sinus operation demands that a proper drainage duct for the unobliterated portion of the sinus must be maintained. This is accomplished by introducing a rubber tube from the sinus to a point near the floor of the nose covering a portion of it, to a point above and below the opening in the bone, with a Thiersch skin graft from the thigh. The tube should be as large as the opening into the nose will accommodate, approximately ½ inch in diameter. Deep horsehair sutures are passed through the skin and muscle to approximate the soft parts to the graft and close the wound. No intranasal packing is used. The sutures are removed on the fourth day and the skin is supported with a gauze strip applied with collodion. On the fifth day the tube is removed.

Both wounds healed promptly. She was seen at intervals for one month as there was some purulent discharge from the left side during that period.

When I examined her April 10th, 1935, she had that day contracted an acute rhinitis. The nasal mucosa was swollen and presented some hyperplastic thickening. Both frontal sinuses were easily entered with a cotton-wound applicator. She gave me the history of having been in excellent health for the past two years, being free from asthma, cough and postnasal discharge. "Colds" had been infrequent and of short duration.

COMMENT

Although it is often contended that it is impossible to completely remove the mucosa and properly inspect the bony walls of the frontal sinus with this exposure, I feel that the orbital approach to this group of sinuses is a satisfactory method of managing infections in this area. However, I do not indorse the opinion that every infection of the ethmoidal cells requiring surgical interference should be handled by this radical method. Past experience certainly justifies us in employing intranasal surgery first in most cases, reserving this radical external method for those patients unsuccessfully operated upon intranasally and for those who in the opinion of the operator would not be relieved by the more conservative intranasal procedure.

Since the external operation can be done under local anesthesia in a practically bloodless field with a resulting negligible scar, preserving the contour lines of the face, it should be done without hesitation when the indications are present.

Obviously when the frontal infection is complicated by osteomyelitis of the anterior wall this technic is not applicable.

Certain instruments have been devised by Ferris Smith and others, more recently by Luongo, which are almost indispensable in carrying out the foregoing technic.

DISCUSSION

Dr. R. A. Luongo, Philadelphia, Pa.: I have nothing to add to this excellent paper. Dr. Kline has concisely and very clearly outlined the development, technic and indications of the operation.

I only want to emphasize the following points:

1. You have all examined the patient and noticed how beautiful the cosmetic results were.

2. The post-nasal discharge and the asthma were relieved for a period of two years.

3. I had the privilege of assisting Dr. Kline when he operated on this patient, and I remember that she had so very little post-operative discomfort that a few days after the first operation she insistently begged to be operated on the other side before leaving the hospital.

4. Lately we have made some modifications of technic which I shall try to illustrate to you with some lantern slides.

STATE SOCIETY ACTIVITIES

EMERGENCY RELIEF ADMINSTRATION

The relations of the physicians of New Jersey to the State Emergency Relief Administration have been defined, and agreements have been made regarding the conditions of rendering medical service to those on State relief. The agreements and the methods to be adopted by physicians are set forth in the following circular letters and forms.

1. AGREEMENT BETWEEN THE MEDICAL SOCIETY OF NEW JERSEY AND THE STATE OF NEW JERSEY EMERGENCY RELIEF ADMINISTRATION

The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration enter into this agreement for the provision of necessary medical care to the clients of the Emergency Relief Administration. This agreement may be terminated at any time by notice from either the Medical Society or the Emergency Relief Administration. All changes in this agreement must be mutually acceptable.

The following policies shall govern any plan devised by the Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration for the provision of medical care to the clients of the Emergency Relief Administration:

1. The preservation of the personal relationship between the doctor and patient shall be held paramount.

2. Medical relief shall be supplied by the individual physicians, preferably by the patient's own or previous physician, which shall insure free choice of physician by clients.

The Emergency Relief Administration shall not suggest the name of any one physician. It may provide a roster of physicians furnished by the County Medical Advisory Committees from which the patient may make choice.

3. The Emergency Relief Administration may authorize payment for medical care as a special or single phase of relief to a family or individual.

4. The Emergency Relief Administration shall not pay physicians for work in clinics or hospitals; nor shall it pay hospitals for admission clinic charges.

5. The physician shall decide whether the patient requires hospitalization; but except in serious emergency the Emergency Relief Administration shall be notified sufficiently in advance of admission to permit it to establish the propriety of accepting public responsibility for hospital charges. When a patient enters a hospital, all fees to a physician cease so far as that particular patient is concerned. Free choice of hospitalization in any accredited hospital shall be permitted.

In obstetrical cases no deliveries shall be undertaken in homes where conditions and surroundings, in the opinion of the attending physician, are not consistent with good obstetrical practice.

6. Only emergency cases shall be certified for operation. Elective operations shall not be authorized for relief clients.

7. Only regularly licensed doctors of medicine shall be authorized to treat clients. This clause shall not, however, prohibit payment by the Emergency Relief Administration to limited licensed practitioners when their services are rendered to clients who are referred to them by doctors of medicine. Neither shall it interfere with necessary treatment which may be given by registered visiting nurses, under medical direction and supervision. It shall not be the policy of the Emergency Relief Administration to substitute midwives for physicans in obstetric cases.

8. Payments by the Emergency Relief Administration for pharmaceuticals shall be limited to the U. S. P., N. F., N. J. Formulary, and such supplementary lists of drugs as may be agreed upon by the Emergency Relief Administration and the Executive State Medical Advisory Committee. Rare exceptions to this rule may be made only upon recommendation of the County Medical Advisory Committee. Physicians should use the less expensive drugs whenever possible.

9. Emergency Relief Administration payments for services rendered by physicians shall be limited to care that is rendered in accordance with the State-wide uniform procedure devised by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration under the terms of this agreement.

ORGANIZATION

In order to carry out these policies, The Medical Society of New Jersey shall appoint

an Executive Medical Advisory Committee whose functions shall be:

1. To establish, in coöperation with the State of New Jersey Emergency Relief Administration, a uniform State-wide procedure for the provision of medical care.

2. To aid in organizing County Medical Advisory Committees.

3. To interpret the agreement to physicians, to local Medical Societies, to County Medical Advisory Committees, and to the public at large.

4. To meet with designated officials of the Emergency Relief Administration to consider jointly problems that may arise and their interpretation under the agreement.

There shall be appointed by the County Medical Society in each county where the agreement is to become operative, a County Medical Advisory Committee whose functions shall be:

1. To provide a list of licensed physicians eligible to treat Emergency Relief Administration clients.

2. To review the medical reports made monthly by physicians and to approve or disapprove these reports.

3. To control Emergency Relief Administration medical practice in their respective counties.

4. To serve in medical matters in an advisory capacity to their County Director; and in general to have the same relation to the County Director as the Executive Medical Advisory Committee has to the State Director.

The Executive Medical Advisory Committee, together with the Chairmen of the respective County Medical Advisory Committees, shall consittute the State of New Jersey Medical Advisory Committee. They shall meet subject to call to review actions of the Executive Medical Advisory Committee and to discuss whatever problems that may arise.

The attached procedure is subject to change at any time by an agreement between the Executive Medical Advisory Committee and the Emergency Relief Administration.

(Signed) Marcus W. Newcomb,
President of The Medical Society of New Jersey

Chester I. Barnard,
State Director, State of New Jersey Emergency Relief Administration

2. PROCEDURE FOR THE PROVISION OF MEDICAL CARE TO CLIENTS OF THE STATE OF NEW JERSEY EMERGENCY RELIEF ADMINISTRATION

The agreement between The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration permits Emergency Relief Administration funds to be paid to individual physicians for services rendered in accordance with the uniform procedure provided for in the agreement. Under the terms of this agreement the procedure detailed herein has been established. Changes in this procedure may be made only by the joint action of the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration.

1. All authorizations for medical care shall be issued in writing on the regular Relief Order blank in triplicate, one copy to be kept by the physician. Telephone authorizations must be immediately followed by a written authorization. No medical services will be paid for unless covered by a written authorization.

If, on an order for medical care, the physician finds more than one member of the family ill, all patients shall be cared for and only one call charged for by the physician.

2. Authorization for emergency service rendered by a family physician may be provided if the physician reports in writing to the Relief Administration within forty-eight hours the name and address of the sick indigent person and the occasion for the emergency visit. Such cases are to be considered as exceptional and the approval, if given, shall be conditioned upon the acceptance by the Emergency Relief Administration of the indigency of the patient to whom such emergency service is given.

3. Authorization for medical care will be issued on an individual case basis. The initial authorization shall be limited to one visit. Subsequent authorizations for continued treatment of a patient, issued at the request of the physician, shall be limited to a maximum of three visits on any one authorization.

4. Medical care for prolonged illnesses, such as arthritis (chronic), and chronic heart disease, shall be authorized on an individual case basis and shall be limited to not more than one visit per week for a period not exceeding one month. Authorization for the further treatment of any chronic case may be authorized only after a review of each case by the County Medical Advisory Committee and each further authorization so granted shall be limited to a period not exceeding one month.

5. Physicians whose names are on the ap-

proved list must be classified as either general practitioners or specialists. If a physician is classified as a specialist, he will be paid only for cases referred to him by other physicians for the treatment of cases in his specialty. A physician listed as a specialist is not eligible to receive payment for general medical practice. Neither is a physician who is listed as a general practitioner eligible to receive a specialist's fee for services rendered as a specialist.

6. Physicians treating Emergency Relief Administration clients must render to the County Medical Advisory Committee a monthly report showing the names (in alphabetical order) of patients treated, the diagnosis of each case and the number of home and office visits made during the month on each case. Bills will not be passed for payment by the Emergency Relief Administration until these physicians' reports have been reviewed and recommendations made by the County Medical Advisory Committee.

7. Fees to physicians shall be established for each county by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration. They shall be based upon one-half to two-thirds of the average fees throughout the county. In no case shall the fees paid to general practitioners exceed $1.00 for an office visit, $2.00 for a home visit, and $25.00 for obstretrical cases. (This fee for obstetrical cases shall include all charges for delivery, the necessary prenatal visits, in no case less than three, and the necessary post-natal care. Details of these services shall be submitted with the bill.) These maximum fees for general medical service shall not apply to fees for specialists that may be established by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration.

8. It is recommended that $250.00 per month be fixed by the County Medical Advisory Committees as the maximum to be paid to any one physician for treatment of Emergency Relief Administration patients. County Medical Advisory Committees may, however, modify this suggestion to serve the best interest of the Emergency Relief Administration and the medical profession in that particular county. County Medical Advisory Committees may recommend and the County Director may pass for payment, bills from individual physicians in excess of $250.00 when such payment is warranted. When such bills in excess of $250.00 are passed for payment, Emergency Relief Administration Headquarters must immediately be furnished with a statement giving the name of the physician, the total amount of the bill, the relief month to which it is chargeable, and the reasons for recommending payment.

9. Monthly bills shall be rendered by the doctors to each Emergency Relief Administration district office from which authorization to provide medical care at public expense has been received. These bills shall be rendered in accordance with the standard billing procedure followed by the Emergency Relief Administration for all types of commodities and services.

Doctors must remember to procure the signature of the patient or the head of the patient's family on all authorizations (form E. R. A. 18R) as auditors will not pass bills unless the signature of the client or the head of his family is so affixed.

10. This procedure is subject to change at any time by the joint action of the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration, but no changes may otherwise be made.

3. LETTER TO ALL COUNTY DIRECTORS AND ALL COUNTY MEDICAL ADVISORY COMMITTEES, SENT AUGUST 7, 1935

The State Emergency Relief Administration has ratified the attached Medical Agreement, which was approved by The Medical Society of New Jersey at the Annual Meeting held in Atlantic City in May, 1935. This agreement will supersede the present agreement and become effective on September 1, 1935.

The State Relief Council has taken action in which the Trustees of The Medical Society of New Jersey concurred at a meeting held in Trenton on July 31, 1935, providing for the signing of an application form by all physicians now on the approved list and physicians who may in the future desire to be paid for treating E. R. A. clients. (Copy attached.)

The present approved list of physicians will expire on August 31, 1935. It is, therefore, necessary that immediate arrangements be made by the County Medical Advisory Committees to supply each physician at present on the approved list with a copy of the Medical Agreement and an application form. Beginning with September 1, 1935, the approved list will be made up exclusively of physicians who have signed the new application form.

The procedure that shall be adopted by each

Medical Advisory Committee shall be as follows:

1. A sufficient supply of the necessary forms is being forwarded to each County Director for distribution to physicians. A set consists of the Medical Agreement, application form, and letter to physicians.

2. The letter to physicians shall have attached thereto a copy of the Medical Agreement and an application form, and shall be immediately sent to each physician now on the approved list. The letter is self-explanatory and provides for the return of the signed application form to the Chairman of the County Medical Advisory Committee by August 17, 1935.

3. On this date, or shortly thereafter, a complete new list of approved physicians shall be compiled in duplicate and the original submitted to the County Director not later than August 24, 1935. The duplicate shall be retained by the Chairman of the Medical Advisory Committee.

4. Future additions to the approved list shall be made only after the County Medical Advisory Committee has approved the physician's written application form and notified the County Director of such approval.

5. The County Director shall supply to each District Office, prior to September 1, 1935, copies of the list of approved physicians.

Wherever possible, the County Director shall supply such clerical help and supplies as are necessary to relieve the County Medical Advisory Committee of the detailed operations of the procedure.

E. ZEH HAWKES,
Chairman Executive State Medical
Advisory Committee.

NORMAN B. TOOKER,
State of New Jersey Emergency
Relief Administration.

4 LETTER TO THE INDIVIDUAL DOCTOR

At the Annual Meeting of The Medical Society of New Jersey held at Atlantic City in May, 1935, a medical agreement was proposed and approved by the Society, and has since been ratified by the State of New Jersey Emergency Relief Administration. This agreement, a copy of which is attached, will supersede the present agreement and become effective September 1, 1935. It is suggested that you thoroughly acquaint yourself with all the provisions of this agreement.

There is also attached hereto an application form which is to be signed by you, if you wish to receive payment for the treatment of E. R. A. clients, and returned to the Chairman of the County Medical Advisory Committee prior to August 17, 1935. This application form was adopted by the State Relief Council at a meeting held on July 23, 1935, and approved by the Trustees of The Medical Society of New Jersey at a meeting held in Trenton on July 31, 1935.

The automatic expiration of the present approved list of physicians on August 31, 1935, and the effective date of the new list of approved physicians on September 1, 1935, make it imperative, because of the necessary clerical operations, that your application form, properly signed, be immediately forwarded to your County Medical Advisory Committee.

No relief orders will be approved for payment after August 31, 1935, unless your application form has been filed with and approved by your County Medical Advisory Committee.

..... County Medical Advisory Committee
(Name of County)

By .....
(Chairman)

Return Application Form to the Chairman.

Address .....

5. PHYSICIAN'S APPLICATION FOR APPROVAL TO RENDER SERVICE TO E.R.A. CLIENTS

Physician's Name .....

Street Address .....

Municipality..... County.....

Phone No. .....

At a meeting of the State Relief Council of the Emergency Relief Administration held on July 23rd, 1935, a resolution was passed providing, "That all physicians eligible to be paid from Emergency Relief Administration funds for medical care and treatment of patients of the Emergency Relief Administration in the State of New Jersey be required forthwith to sign and file with the Emergency Relief Administration Medical Advisory Committee of each county an agreement".

In order that you may be eligible to provide medical care and treatment to E. R. A. clients, the following agreement must be signed by you and immediately returned to the County Medical Advisory Committee at the County Office. Consideration of your application will be immediately made and notice of the action taken will be sent to you.

1. I, ..., will render medical care in accordance with the terms set forth in the agreement between The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration.

2. The County Medical Advisory Committee may adjust or disapprove payment of bills which I may submit; or may remove my name from the list of approved physicians, when such action shall, in its opinion, be to the best interest of the State of New Jersey Emergency Relief Administration.

Dated..... Signed.....M.D.
Application rec'd on .....
Approved by Co. Medical Advisory Com. on .....
By .....
District Off. n't'f'd on .....
Physician n't'f'd on .....
Application filed on .....
General Practitioner .....
Specialist .....
(Specify)

PUBLIC HEALTH COMMITTEE

A meeting of the Public Health Committee of The Medical Society of New Jersey was held on Sunday, July 14th, 1935, at the home of the Chairman, Dr. Stanley Nichols, in Long Branch. Those present were: Drs. Nichols, Levy, Teimer, Ireland, Kahrs, Hummel, Knight, Frankel, Mahaffey, Casselman, Mr. MacDonald, and Dr. Wilkes, Secretary.

Announcement was made of the honor conferred on Dr. Mahaffey by the American Public Health Association in making him Vice-Chairman of the Section on Public Health and Industry.

PUBLIC HEALTH COUNCIL

Dr. Nichols presented a tentative outline prepared by the Secretary for the development of the Public Health Council, which will be composed of representatives from all other health committees.

General discussion on this outline as to the name and functions of the Council was held.

POLIOMYELITIS SERA

The next question considered was the two types of polio-sera developed,—one by Dr. Park, of New York, and another by Dr. Kolmer, of Philadelphia.

Emphasis was made that these sera are still in the experimental stage and that a long period of mass clinical tests must precede the general application and final acceptance of this serum by the medical practitioners.

It was agreed that a committee be appointed to study the problem of polio-serum, and to make recommendations to the State Medical Society with regard to the use of this serum. Among those suggested for membership on the Polio Committee were: Dr. Connolly, of Newark, and Dr. Kilduffe, of Atlantic City.

BABY KEEP WELL STATIONS

The next subject for consideration was the standards of qualifications for pediatrists and physicians in the Public Health Baby Keep Well Stations. Dr. Levy briefly outlined these recommendations as follows:

1. They be recommended by the County Medical Societies and appointed for one year.
2. They be in the exempt class of civil service.

3. They preferably be pediatrists or physicians who are especially interested in pediatrics.

4. The doctors selected should take part in special courses of training to be provided through the Social Security Bill funds.

These recommendations were unanimously approved.

Dr. Levy suggested that the Medical Society give aid in this movement by definitely approving the "Baby Keep Well Stations", and urging physicians interested in this work to take part in the conduct of the stations. This suggestion will be presented to the Welfare Committee, and also to Dr. Lewis' Committee on Medical Practice, together with the standards for approval. Dr. Lewis' committee will recommend who shall be admitted to the Baby Keep Well Stations, i. e., the upper limits of the low income level people eligible to such free stations.

SOCIAL SECURITY BILL

The next discussion was centered on the House of Representatives Bill 7260 (Social Security Bill), introduced by Senator Wagner. Dr. Nichols reported that he was one of three members (Russell, MacNaughton and Nichols) of the State Board of Health who constitute the committee appointed to study the *health aspects* of the provisions in the Social Security Bill.

Secretary Wilkes outlined the provisions of the bill. He emphasized the *general* nature of the provisions and stated that the catagories of service were really categories of groups to be served. The bill appears to leave the details of organization and administration in the hands of the state authorities, subject to the approval of the Children's Bureau and the Public Health Service of the Federal Government.

Dr. Nichols stated that it was probably a question of what *New Jersey* wanted that would determine the New Jersey program. This seemed to be the consensus of opinion of the members of the Public Health Committee.

Mr. MacDonald of the State Health Department pointed out that the present administrative organization advocated by the U. S. Public Health Service was quite *out of line* with the present organizations of the local health departments, and would involve considerable legislative changes as well.

The provisions of the public health aspects of the Social Security Bill was quite indefinite as to whether provision will be made for travel and supplies as well as personnel.

Mr. MacDonald stated that one of the problems in New Jersey was tuberculosis in negroes, which is also a national problem, though he felt something could be done to solve the problems in Newark and Atlantic City through better housing.

General discussion emphasizing the need to provide ways and means to meet New Jersey's needs locally, rather than plan on them in Washington, took place.

Dr. Mahaffey spoke of some of the sanitary problems. He mentioned especially road-side food stands, which he felt should be under constant investigation and supervision.

Dr. Nichols pointed out the provisions in the bill under which health education and "refresher courses" could be given to the personnel already on the job.

Dr. Levy stated that his program as Director of the State Division of Child Hygiene was developed in accordance with the ideas and suggestions set forth in the bill; and that he felt maternal and child mortality could be attacked favorably, and most economically and effectively, through direct efforts to enlist the physicians themselves in coöperation with the State Medical Society. He pointed out that the efforts of the State Health Department personnel to influence the physicians in practice were not always effective and were often difficult. He felt that a coöperative program of urging the doctors through their own State Medical Society had much more promises of results.

If a coöperative program were developed, the medical practitioners themselves would be directly supervised by committee members of the State Medical Society.

Dr. Teimer stated that he felt that a clinic demonstration by physicians was more effective than didactic lectures as post-graduate training.

Dr. Levy's program proposed to pay physicians in the Baby Keep Well Stations and in the prenatal clinics. It also offers consultation service in obstetrics to low-income families, the fee to be paid from the government funds.

Additional child hygiene nurses are needed to cover the territory not now supplied. Labor nursing service formerly had one thousand cases a year, but now they do not have any nursing help for the doctor.

Dr. Levy's budget shows approximately $74,000.00.

VENEREAL DISEASE CONTROL

Dr. Casselman presented a budget of $70,000.00, which showed good initiative and planning to meet some of the needs fixed by the

Venereal Disease Bureau of the New Jersey State Department of Health.

It was estimated that five per cent of the population of New Jersey had syphilis and that the large percentage of this is among the low-income level group.

Dr. Casselman figured that at a cost of five dollars for materials he could provide twenty doses of neo salvarsan and twenty doses of bismuth, and that medical service for the use of these drugs could be made available for the low income group at the charge of one dollar in the office of the physician.

Dr. Casselman also recommended provision to expand the facilities for dark-field examinations for spirochetes, and for additional laboratory facilities in the State laboratories to provide for more Wassermann examinations. Also he will provide for the payment of physicians working in the clinics and for pamphlets which are to be distributed free.

NURSING SERVICE

The proposal to establish a nursing service division in the State Department of Health was considered to be primarily a question for the consideration of the Committee on Nursing and Nursing Education of the Medical Society after which it would be discussed by the Public Health Committee. In the limited discussion on this subject which ensued no enthusiasm for such a division was manifested.

Meeting adourned at 6 p. m., after a three-hour session.

THE SOCIAL SECURITY ACT

Reference was made to the national *Social Security Act,* House of Representatives Bill 7260, in The Journal of August, page 502. This Act, commonly known as the *Wagner, Doughton, Lewis Bill,* from those Senators who sponsored it, was signed by President Roosevelt and became a law on August 14. Its principal features are those contained in the first draft of the Bill, an abstract of which, prepared under the auspices of the American Medical Association, was published in The Journal of February 1935, page 106.

The Law provides for national aid to the several States in welfare work along nine lines:

1. Old-age assistance.
2. Unemployment compensation.
3. Aid to dependent children.
4. Maternal and child health services.
5. Crippled children.
6. Child welfare.
7. Vocational rehabilitation.
8. Public health services.
9. Aid to the blind.

The Law, unusually brief and concise, is contained in a pamphlet of 32 pages, which makes provision along four general lines:

1. It requires each State to set up, or to designate, a department or agency for each of the nine activities mentioned in the Law, which will administer the distribution of the national funds allocated to it.

2. It sets up a national Board of three members whose duty is to administer the Law, and especially to decide all questions regarding the compliance of the States with the Law.

3. It appropriates money to be distributed to the States on the condition that, in general, each State must also make substantial appropriations of its own funds to the same objects. The amount of national money appropriated for each project is as follows:

1.	Old-age assistance	$50,000,000
2.	Unemployment compensation	4,000,000
3.	Dependent children	250,000
4.	Maternal and child health	3,800,000
5.	Crippled children	2,850,000
6.	Child welfare	1,925,000
7.	Vocational rehabilitation	841,000
8.	Public health services	10,000,000
9.	Aid to the blind	3,000,000
		$76,766,000

These appropriations are the sums named for the first year only. They are increased, often many fold, for succeeding years.

It is a question that any Federal money at all will be available during several months, for when Congress adjourned on August 27 it had not included Social Security money in the appropriations in its budget bill.

OLD-AGE ANNUITY

The Act proposed to make the project of old-age assistance self-supporting by assessing both the employed and the employer in order to create a fund or "old-age reserve account" to be invested in Government bonds, and the accumulated proceeds to be applied as an annuity to every insured person who reaches the age of 65 years. The annuity payments will begin in 1942; and after that date the sum to be paid to each person insured will be in proportion to the amount that the individual has

paid, with provision for maximum and minimum amounts. The assistance will be begun as soon as the machinery can be set up.

LEADERSHIP BY THE STATE SOCIETY

The Law requires that each State shall administer the funds for each of the nine projects by designating an existing agency, or setting up a new one to administer it, subject to the approval of the Federal Security Board. The Medical Society of New Jersey with its usual promptness anticipated the administration of the Law by calling a conference of representatives of the present health and welfare agencies of the State in order to determine the best means of carrying out the Law. This conference was held on June 26, six weeks before the enactment of the Law, and was reported in this Journal of July, page 440.

It is understood that the Department of Institutions and Agencies will take the leadership in making the necessary studies and formulating the appropriate plans to be presented to the National Social Security Board which will be established according to Title VII of the Law. The Medical Society of New Jersey may be relied on to continue its activity and coöperation, which it demonstrated by calling the first conference for the consideration of the Law. By the active participation of all the State Agencies, the establishment of wise methods for administering the Federal Law in New Jersey is assured.

LETTER FROM THE FEDERAL COMMITTEE ON ECONOMIC SECURITY

Mr. Merrill G. Murray, Acting Executive Director of the Committee on Economic Security, 1734 New York Avenue, N. W., Washington, D. C., has sent out the following letter:

"Enclosed you will find a copy of the Federal Social Security Act as approved August 14, 1935, together with an analysis of the various provisions of the Act.

"With the exception of Titles II and VIII, dealing with Federal old-age benefits, the entire Social Security Act is based upon the principle of Federal-State coöperation. It will therefore be necessary for the States to act in order to secure the benefits accruing from the Federal Act. In many cases, this will be possible by State administrative action; but in some cases, amendments to existing State laws or new State legislation will be necessary.

"Until the Social Security Board, provided by the Act, is appointed and begins to function, a skeleton staff will be maintained by the Committee on Economic Security to answer inquiries regarding the Social Security Act, and to assist such States as wish to immediately initiate study or action on State social security measures.

"Please feel free to call upon us for any such services you may need."

GOVERNOR'S CONFERENCE

In accordance with Senate Joint Resolution number 17, passed on May 18, Governor Hoffman has appointed the following members of a Conference to consider the provisions of the Federal Social Security Act as they apply to New Jersey:

Senators—

John C. Barbour, Clifton, Passaic County
S. Rusling Leap, Woodstown, Salem County
Blase Cole, Newton, Sussex County.

Assemblymen—

Marcus W. Newcomb, Browns Mills, Burlington County.
Henry Young, Jr., Newark, Essex County
Dayton D. McLean, Princeton, Mercer County

Lay Members—

Harry L. Derby, Vice-President American Cyanimid Corporation, Montclair, Essex County
William J. Ellis, Commissioner of Institutions and Agencies, Trenton, Mercer County
Mrs. Elizabeth Harris, Freeholder, Essex County, Glen Ridge, Bergen County
Vincent P. Murphy, Secretary, State Federation of Labor Commission, Newark, Essex County
Robert P. Fischelis, President, Conference of Allied Medical Professions, Trenton, Mercer County
John Toohey, Jr., Commissioner of Labor, Trenton, Mercer County
Frederick S. Kellogg, General Counsel of the New Jersey Manufacturers' Association, Montclair, Essex County

The Conference met at the Governor's Cottage, in Sea Girt, on August 13, and elected the following officers:

Chairman, Harry L. Derby.
Vice-Chairman, Mrs. Elizabeth Harris.
Secretary, William J. Ellis.

The Conference is now collecting material and making a comparison of the New Jersey Laws with the Federal Laws, in order to harmonize them in respect to the administration of the Federal Social Security Act.

HOSPITAL SURVEY

It is planned that the Hospital Survey for New York City shall cover not only New York City but also Westchester and Nassau Counties and the western tip of Connecticut; and shall also include the Metropolitan Area of New Jersey, which consists of the Counties of Hudson, Essex, Union, Passaic and Bergen. The medical societies of these counties have approved the survey and are making available the facilities of their offices for an inquiry of physicians' relations to hospitals.

The Survey is conducted by the United Hospital Fund of New York City, whose headquarters are at 370 Lexington Avenue, New York City, telephone Caledonia 5-7150. The committee is under the chairmanship of Dr. George E. Vincent, and the Director of Study is Dr. Haven Emerson, Professor of Preventive Medicine in the College of Physicians and Surgeons.

The Study Committee consists of:

Dr. S. S. Goldwater, Commissioner of Hospitals.
Dr. Willard C. Rappleye, Dean, College of Physicians and Surgeons.
Dr. Nathan B. Van Etten, Speaker of the House of Delegates, A. M. A.
Dr. Charles Gordon Heyd, Surgeon, Post-Graduate Hospital.
Dr. John E. Jennings, Surgeon, Brooklyn Hospital.
Dr. Eugene H. Pool, President of the New York Academy of Medicine.

An essential part of the plan of the Survey is that a postal card questionnaire shall be sent to every practicing physician in Greater New York and the metropolitan area of New Jersey. The chief object of the questionnaire is to ascertain:

1. How many physicians who are engaged in private practice are on the organized staffs of hospitals or out-patient services.
2. Whether or not physicians who are not on hospital staffs can hospitalize their private patients and receive fees for their services.

The questionnaire is as follows:

Please read the questions carefully and answer all of them.
N. B. In replying, check *yes* or *no*, after each question.

Are you in private practice? Yes . . No . . .
Are you a member of the organized attending staff of any:

	State or Federal		Municipal or County		Voluntary		Proprietary	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Hospital In-Patient Service . .								
Hospital Out-Patient Service . .								

Are you a member of the attending staff of any Independent Clinic? . . . Yes . . No . .
Is there any hospital (voluntary or proprietary) in your vicinity to which you can have your private patients admitted under your own care on a fee basis?

Voluntary . . . Yes . . . . No . . . . Proprietary . . . Yes . . . . No . . . .

Have you need for access to a hospital? Yes . . . No . . .
Have you multiple hospital connections? Yes . . . . No . . . .

Signature .....

Address ..... St. ..... City ..... County ..... State

Graduated from ..... *Year* .....

The Medical Society of New Jersey and the County Societies are placing the facilities of their offices at the disposal of the Survey Committee. The findings will be as valuable to the local counties as to the greater Committee.

This project is approved by The Medical Society of New Jersey and by the County Societies of the five counties in which the survey is to be made. It is hoped that all physicians will give the questionnaire their hearty attention. All expenses of this inquiry will be met by the Hospital Survey.

AUTOMOBILE INSURANCE

To the Members of The Medical Society of New Jersey:—

The Committee on Insurance writes you this as a bulletin of information on recent events in the *Automobile Insurance* hitherto written by the Manufacturers' Casualty Insurance Co. of Philadelphia.

The Company has terminated its contract with the Way Agency Inc., and opened its own agency in Newark to deal directly with policy-holders. It was a surprise to us and was done without their advising us (which they admit they should have done). We have awaited developments to be sure of any advice to give you, but now can report as follows:—

The Department of Insurance at Trenton in the matter of "the Manufacturers' Casualty Insurance Co. against the Way Agency" decided (August 2nd) that it "will not entertain a complaint nor hold a hearing; and insofar as the Department is concerned the matter is closed"; further, (August 5th) that "there is no foundation for the rumor the Agency's license would be revoked, as the above action stands and will stand." The agency has entered a suit in the Supreme Court against the Manufacturers' Co. in the sum of $50,000, for "damages by reason of wilful and malicious action of the Company."

Two things are essential for the satisfaction which has characterized the success of our insurance through the years:—

1. The financial *security* of the underwriting Company and
2. The efficient and interested *service* of the Agency.

Both have had our constant care.

The Way Agency has given our members extraordinary service, giving, beyond what the policies cover, other attentions and services which are appreciated judging by the increase in number of our policy-holders which has been from 533 in June 1933 to 1428 this summer (165 per cent). The liability insurance they recommend now is with the Atlantic Casualty Insurance Co., guaranteed 100 per cent by the Excess Insurance Company of America (having capital and surplus of $1,768,000. and assets of $5,281,000) whose rating by the insurance authorities is "A+" (the very highest).

No existing policies are in the least affected by this change in agencies and our members may feel fully secure. When it comes to renewal of a policy or taking new insurance, consult the Way Agency if you want all the service we have been having.

Consult our *Annual Report* in the Transactions, July 1933, p. 17; also, for particulars about both the Automobile and the Health & Accident Insurance, the State Society Journal, January 1935, p. 38.

The Committee on Insurance,
FRANK W. PINNEO,
August 22, 1935. Chairman.

BOARD OF MEDICAL EXAMINERS

Following is the report of the activities of the State Board of Medical Examiners of New Jersey in enforcing the Medical Practice Act since our last report, which was published in this Journal of March, 1935, page 165.

3/4/35—Marie Cederberg and Elna Notman, who conducted the Princeton Health Studio in Princeton, New Jersey, pleaded guilty to a charge of practicing medicine without a license, and paid the penalty.

3/8/35—James A. Mackey, an unlicensed chiropractor of Trenton, New Jersey, pleaded guilty to a charge of practicing medicine without a license. He refused to pay the penalty and was committed to jail for seven days.

Mar. 1935—Edward B. Seeley, a masseur of Englewood, New Jersey, paid the penalty for practicing medicine without a license.

4/23/35—Joseph Spector, a registered pharacist, of Elizabeth, New Jersey, pleaded guilty to a charge of practicing medicine without a license.

6/2/35—Reuel B. Haggett, who claimed to cure a disease by a method which he had perfected consisting of the administration of a saline solution, was found guilty of practicing medicine without a license by the Judge of the Englewood District Court. He was unable to pay the penalty and was committed to jail.

6/1/35—Charles W. Morey, a naturopath, of North Arlington, New Jersey, pleaded guilty to a charge of practicing medicine without a license before the Judge of the Englewood District Court and paid a penalty after spending a few days in jail.

5/14/35—Michael Jaroslaski, a "Hex Doc-

tor", who was treating a crippled child in Jersey City, was tried on a charge of practicing medicine without a license before Judge Eggers in the First District Court of Jersey City, and found guilty. He was committed to jail for one hundred days, but paid the penalty a few days after his commitment.

5/22/35—Elias B. Weissberg, a licensed osteopath, of Atlantic City, pleaded guilty to a charge of practicing medicine without a license before Judge Jeffers of the Atlantic City District Court, and was committed to jail.

5/23/35—Charles W. Remboy, an "Herb Dr", of Butler, New Jersey, was tried before Judge Scerbo of the Morristown District Court and found guilty of practicing medicine without a license. He was unable to pay the penalty and was committetd to jail for thirty days.

6/10/35—August Miroch, a Naturopath, of Bloomfield, New Jersey, pleaded guilty to a charge of practicing medicine without a license before Judge McMahan of the First District Court of Newark, and paid the penalty.

6/11/35—Silver Tropeano, of Orange, New Jersey, pleaded guilty to a charge of practicing medicine without a license before Judge McMahan of the First District Court of Newark. He was unable to pay the penalty and was committed to jail.

6/11/35—Cleon E. Shields, who claimed to improve impaired hearing by the use of a machine called "Auratone", pleaded guilty to a charge of practicing medicine without a license before Judge McMahan of the First District Court of Newark and paid the penalty. According to the literature, "Auratone" is an apparatus which accurately measures the capacity to hear (consequently locates and determines the degree of impairment), and then furnishes, in correct volume, the tones that are "blocked out" by the impairment.

6/27/35—William F. Ruther, a druggist, of Oxford, New Jersey, was arrested for practicng medicine without a license and paid the penalty to the Clerk of the Philipsburg District Court.

June 1935—Philip P. Cron, a druggist, of Somerville, New Jersey, paid a penalty for practicing medicine without a license, to the Attorney General.

6/20/35—Ernest A. Ecsery, an unlicensed chiropractor, of Kearny, New Jersey, pleaded guilty to a charge of practicing medicine without a license, before Judge Eggers of the First District Court of Jersey City.

June 1935—Malcolm Satzger, a masseur, of North Bergen, New Jersey, paid a penalty for practicing medicinne without a license.

7/24/35—Anton Robitsek and John Lane, druggists, of New Brunswick, New Jersey, pleaded guilty to charges of practicing medicine without a license before Judge Morrison, sitting in the Perth Amboy District Court.

8/6/35—Agostina Lettieri, a druggist, of Woodcliff, New Jersey, paid the penalty for practicing medicine without a license.

8/15/35—Julian Cyzykowski, of Englishtown, New Jersey, who prescribed herbs and salves to be used internally and externally, was tried before Judge Thomas Brown in the Court of Common Pleas of Monmouth County and was found guilty of practicing medicine without a license.

8/15/35—The charge of practicing medicine without a license against Ralph Cottrell, of Allenhurst, New Jersey, was tried before Judge Brown in the Court of Common Pleas of Monmouth County, and a judgment was entered for the State. As the defendant did not appear in Court, the Judge signed an order committing him to jail for thirty days.

8/22/35—Nicholas Farmakis, of Orange, New Jersey, was arrested on a charge of practicing medicine without a license, pleaded guilty before Judge Masucci and was committed to jail.

4/25/35—The license to practice midwifery in the State of New Jersey of Elizabeth Jordan, of Elizabeth, New Jersey, was revoked by the Board.

3/27/35—The license to practice medicine and surgery of Thomas Sheppard, of Millville, New Jersey, was revoked by the Board.

7/20/35—The license to practice midwifery of Elizabeth Woloshin, of Perth Amboy, New Jersey, was suspended by the Board for a period of one year.

The Board requested Judge Eggers of the First District Court of Jersey City to dismiss the charge of practicing medicine without a license against Arthur Smith, due to the fact that he was tried before Thomas H. Brown in the Quarter Sessions Court of Hudson County, on an indictment of performing an illegal operation and sentenced to serve ten years in the State Prison.

Very truly yours,

ARTHUR W. BELTING, M.D.,
Secretary.

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

A meeting of the *Conference of Allied Medical Professions* was held on July 11th, 1935, at 2:30 p. m. in the offices of The Medical Society of New Jersey at 137 East State Street, Trenton, N. J. Those present were Dr. Fischelis of the Pharmaceutical Society, presiding; Drs. Lewis and Wilkes of the State Medical Society; Drs. Owens and Jennings of the Dental Society; and Miss Ashmun and Miss Watson of the Nursing Organization.

Dr. Fischelis read a letter from Governor Hoffman suggesting that three names from each of the four groups of the Conference be sent to him for the selection of a member on the State Commission to study the Federal Economic Security program. Dr. Lewis moved that each professional group suggest three candidates for representatives on this Commission. Dr. Jennings seconded the motion, which was carried.

The subject of housing the offices of various State Departments now located outside of the State House and annexes and its possible effect upon the control of the professional Boards was discussed at length.

Dr. Lewis moved that the four examining Boards represented by the professions holding membership in the Conference be requested to supply information of their activities suitable for compilation into a pamphlet for distribution to the public. The motion was seconded by Dr. Jennings and carried.

The proposed changes in the methods of the Emergency Relief Administration were considered. The members of the Conference recognized the wisdom of adapting the methods to existing conditions and seeking perfection by the evolution of tried methods.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1935

DIPHTHERIA TOXOID

County	To July 31	Month of August	Total to Aug. 31	Average per Month
Atlantic	26	5	31	15.5
Bergen	40	28	68	34.
Burlington	32	9	41	20.5
Camden	22	16	38	19.
Cape May	48	25	73	36.5
Cumberland	139	66	205	102.5
Essex	359	330	689	344.5
Gloucester	15	28	43	21.5
Hudson	2	0	2	1.
Hunterdon	0	1	1	.5
Mercer	4	4	8	4.
Middlesex	88	56	144	72.
Monmouth	18	17	35	17.5
Morris	91	29	120	60.
Ocean	2	0	2	1.
Passaic	360	95	455	227.5
Salem	8	6	14	7.
Somerset	49	11	60	38.5
Sussex	0	0	0	0.
Union	130	116	246	123.
Warren	86	1	87	43.5
Totals	1519	843	2362	1181.

SMALLPOX VACCINE

County	To July 31	Month of August	Total to Aug. 31	Average per Month
Atlantic	16	2	18	9.
Bergen	62	55	117	58.5
Burlington	31	31	62	31.
Camden	29	35	64	32.
Cape May	52	20	72	36.
Cumberland	111	116	227	113.5
Essex	285	208	493	246.5
Gloucester	20	117	137	68.5
Hudson	1	0	1	.5
Hunterdon	5	4	9	4.5
Mercer	1	1	2	1.
Middlesex	75	79	154	77.
Monmouth	4	0	4	2.
Morris	60	43	103	51.5
Ocean	6	2	8	4.
Passaic	147	323	470	235.
Salem	8	24	32	16.
Somerset	77	17	94	47.
Sussex	0	0	0	0.
Union	151	204	355	177.5
Warren	37	34	71	35.5
Totals	1178	1315	2493	1246.5

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING JULY, 1935

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Lacy N. Conoly	44	July 9, 1935	Cooper Hosp., Camden	601 Walnut St., Camden	Essential hypertension, malignant type. Uremia.
James Hewson	68	July 8, 1935	Beth Israel Hosp., Newark	163 Myrtle Ave., Millburn	Duodenal ulcer. Pulmonary embolus.
Clark S. Long	47	July 17, 1935	Swainton	503 Walnut St., Lansdale, Pa.	Coronary thrombosis. Chronic myocarditis.

COUNTY SOCIETY REPORTS

DATES OF MEETINGS OF COUNTY MEDICAL SOCIETIES OF NEW JERSEY

September 1935—July 1936

SEPTEMBER 1935

10	Bergen	18	Middlesex
10	Sussex	19	Gloucester
12	Burlington	19	Morris
12	Passaic		

OCTOBER

1	Camden	10	Passaic
1	Cape May	10	Somerset
1	Hudson	11	Atlantic
8	Bergen	11	Salem
8	Cumberland	15	Warren
9	Mercer	16	Middlesex
9	Ocean	17	Gloucester
9	Union	22	Hunterdon
10	Burlington	23	Monmouth
10	Essex		

NOVEMBER

5	Camden	14	Essex
6	Hudson	14	Passaic
8	Atlantic	20	Middlesex
12	Bergen	21	Gloucester
13	Mercer	27	Monmouth
13	Ocean		Sussex
14	Burlington		

DECEMBER

3	Camden	12	Passaic
3	Hudson	12	Somerset
10	Bergen	13	Atlantic
11	Mercer	13	Salem
11	Ocean	18	Middlesex
11	Union	19	Gloucester
12	Burlington	19	Morris
12	Essex	25	Monmouth

JANUARY 1936

7	Camden	14	Bergen
7	Hudson	14	Cumberland
8	Mercer	15	Middlesex
8	Ocean	16	Gloucester
9	Burlington	21	Warren
9	Essex	22	Monmouth
9	Passaic	28	Hunterdon
10	Atlantic		Sussex

FEBRUARY

4	Camden	13	Passaic
4	Hudson	13	Somerset
11	Bergen	14	Atlantic
12	Mercer	14	Salem
12	Ocean	19	Middlesex
12	Union	20	Gloucester
13	Burlington	26	Monmouth
13	Essex		

MARCH

3	Camden	12	Passaic
3	Hudson	13	Atlantic
10	Bergen	18	Middlesex
11	Mercer	19	Gloucester
11	Ocean	19	Morris
12	Burlington	25	Monmouth
12	Essex		Sussex

APRIL

7	Camden	10	Atlantic
7	Cape May	10	Salem
7	Hudson	14	Bergen
8	Mercer	14	Cumberland
8	Ocean	15	Middlesex
8	Union	16	Gloucester
8	Passaic	21	Warren
9	Burlington	22	Monmouth
9	Essex	28	Hunterdon
9	Somerset		

MAY

5	Camden	14	Essex
5	Hudson	14	Passaic
8	Atlantic	20	Middlesex
12	Bergen	21	Gloucester
13	Mercer	27	Monmouth
13	Ocean		Sussex
14	Burlington		

JUNE

9	Bergen	17	Middlesex
10	Mercer	18	Morris
11	Burlington	24	Monmouth
11	Somerset		

JULY

9	Burlington	21	Warren
14	Cumberland	28	Hunterdon

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

THE ISOLATION HOSPITAL OF ESSEX COUNTY

The *Essex County Isolation Hospital* has recently extended its services and privileges to a large group of Essex County physicians. Any member of the staff of a recognized hospital in Essex County will be allowed the same privileges in caring for his private and semi-private patients in the Isolation Hospital as he would have in his own hospital. This new policy follows the following resolution that was passed by the Medical Advisory Board of Essex County Isolation Hospital and approved

by the Board of Chosen Freeholders of Essex County:

"Resolved: That any physician in Essex County be extended the privilege of caring for a private or semi-private patient at the Essex County Isolation Hospital, provided:

"First, that he or she is a member of a County Medical Society.

"Second, that he or she is a member of the Consulting, Attending or Assistant Attending Staff of any hospital in Essex County which is recognized by the American Medical Association or by the Fellows of the American College of Surgeons."

Such recognized hospitals have been so notified.

Endorsement of the above policy took the form of the following resolution which was adopted by the Council of the Essex County Medical Society: "Resolved, the Council of the Essex County Medical Society hereby expresses its appreciation of the good work performed by Dr. William Areson, Director of the Essex County Isolation Hospital, in securing the adoption of the new policy by the Essex County Board of Freeholders permitting Essex County physicians who are not members of the hospital staff to take care of their own private and semi-private patients in the Isolation Hospital."

ESSEX COUNTY STUDIES WASHINGTON PLAN

The Essex County Medical Society seems strongly inclined to offer to its patients the services of a *Medical and Dental Bureau* similar to the one operated by the professions in Washington, D. C. The move to establish such a service has been made in coöperation with the *Welfare Federation* of Newark.

In order to get first-hand information on the operation of the bureau in Washington, the following visited that city: Miss J. Isabel Sims for the Welfare Federation, Drs. J. H. Lowrey, A. C. Zehnder and H. H. Satchwell for the physicians, and Drs. Anton J. Krebs and John Scott for the dentists.

Designed to coördinate all public agencies dealing with medical and dental care, steps are being taken to establish within the Federation, starting January 1, 1936, a bureau for medical-dental service modelled after the one now being operated by the Medical Society of Washington.

The move has the unanimous endorsement of the Executive Council of the Essex County Medical Society, which considered the question and passed a resolution of approval at a special meeting called by Dr. John F. Condon, President.

Through the proposed bureau it is hoped that there will be a reduction in expense to the community, less duplication of effort and activities, and at the same time a more extensive service provided for the public.

The Federation looks forward to doing something beside simply raising money and distributing it to the hospitals on a basis largely in proportion to their deficits or to what they have received in the past. It will attempt to fulfill the Federation's larger function, that of being a coördinating agent; coöperating with the hospitals and with the medical profession (that receives little compensation) in the hospitals and the Federation.

At the Federation meeting on Wednesday, May 15th, the following resolutions were offered by Dr. Wells P. Eagleton, Chairman of the Federation's Sub-committee on Hospitals: (1) "That steps be immediately taken for the establishment, by January 1st, 1936, within the framework of the Welfare Federation, of a 'bureau for medical-dental service' modelled upon one which was organized and is now operated by the Medical Society in Washington, D. C." Such alterations as local conditions render advisable shall be made, utilizing the personnel now functioning under the Financial Secretary and the Welfare Director. (2) "That the funds necessary for its establishment shall be included in the next budget of the Community Chest."

It was suggested that for medical matters the officer in charge of the Bureau be a licensed physician and a member of the Essex County Medical Society; and that he have as *Advisory Council* a committee of medical men which is already formed, consisting of:

a. All medical members of the Board of Trustees of the Welfare Federation;

b. The Medical Directors or the Presidents of the staffs of all the hospitals which are members of the Welfare Federation;

c. The Medical Directors or the Presidents of the staffs of the two Catholic hospitals—St. Michael's and St. James's;

d. The Medical Directors of the Newark City Hospital and of the Hospital for Contagious Diseases at Soho;

e. Two medical men appointed by the County Medical Society who are not engaged in the active management of any medical institution;

f. One representative of the Essex County Dental Association.

Most of the hospitals have expressed their desire to participate in the activities of such a coördination.

The plan for the establishment of a "Bureau for Medical and Dental Service within the framework of the Community Chest" has been thoroughly investigated and endorsed by the Public Health Committee of The Medical Society of New Jersey and the Committee on Hospitals of the Essex County Medical Society.

Dr. Ross Garrett, the organizer and director of the professional bureaus in Washington, was in Newark two days studying the local problem. He addressed a meeting of interested persons at the Chamber of Commerce, Newark, which meeting was followed by the enthusiastic endorsement of the plan by the Welfare Federation Trustees. Dr. Ross Garrett is advising the local committee, the Medical Dental Bureau Sub-committee of the Economics Committee, during the preliminary steps toward organization and incorporation of the Essex Medical Dental Bureau.

Dr. Frank Pinneo, Secretary of the Essex County Medical Society, visited Washington and there observed the operation of its Bureau.

Similar institutions are either being operated or organized by the medical and dental professions in St. Louis and Kansas City. Essex County E. R. A. Director Jones offered the cooperation of his organization. This is most valuable as his bureau has already indexed about 250,000 persons as families.

MIDDLESEX COUNTY

Karl Rothschild, M.D., Reporter

The last meeting prior to the Summer vacation days was held on June 19, at the State Home for Boys in Jamesburg. The program was arranged by Dr. Matthew Molitch, Medical Advisor of the Institution. This session was a joint meeting of the Medical Society and the Ladies' Auxiliary. The meeting was very well attended.

To start a good spirit, a pleasant meal was served in the large dining room of the institution and one was wondering what those nice boys, who acted as waiters, might have done to society to become confined to a State Home for Boys.

The dinner was followed by a session of addresses delivered by Mr. Derrick, the director of the State Home for Boys, Dr. Molitch, and Dr. Haywood, the president of the Society. These men all stressed the advances that have been made in recent years in the handling of prisoners and of wayward boys. Special emphasis was laid on the psychiatric treatment of such cases, it being the opinion that medicine, even now, does not receive its full share of credit and an even chance.

These speakers were followed by the President of the State Medical Society, Dr. Marcus Newcomb, who delivered a speech of appreciation for the joint meeting of the Society with the Ladies' Auxiliary, and spoke about the working of the *Uniform Practice Act*, as well as the deficiencies of the *New Food and Drug Act* which is being evolved in Washington.

Several members of the State Ladies' Auxiliary, as well as Mrs. Howley, President of the Middlesex County Ladies' Auxiliary, gave words of greeting.

Dr. LeRoy A. Wilkes, Executive Secretary of the State Society, gave an interesting talk about new bills being enacted in various states; and, in general, condemned the activities of those trying to force medical procedures on us from the outside rather than have the medical profession develop new procedures from within their own ranks.

The speeches were interspersed with the rendition of songs by a colored quartet under the leadership of Mr. Miner. These songs were well acclaimed as an example of how modern institutions try to utilize and encourage artistic inclinations in inmates.

Dr. Molitch conducted a session at the institution's hospital in which he demonstrated a number of cases with marked endocrine disorders. It is his belief, to which the present reporter heartily subscribes, that there is a definite relationship between criminology and endocrinopathies, although the relationship is not as simple as the exposition of well-pronounced cases might suggest.

The thanks of the Society are due to Dr. Molitch and the administration of the State Home for Boys for arranging this interesting scientific and social program.

OCEAN COUNTY

Abraham Goldstein, M.D., Reporter

ALFRED WOODHOUSE, M.D.

Dr. Alfred Woodhouse, President of the Ocean County Medical Society, died August third, 1935, aged 56 years. He was born in Cradely Heath, England, June 26, 1879, and graduated from Hahnemann Medical College in 1904. He practiced medicine in Newark, N. J., until 1918, and then in Bristol, N. H., until 1924, except for a period of active service in the World War. He then practiced his profession in Toms River, N. J., for eleven years, and was Secretary of the Ocean County Medical Society for four years, and was inaugurated President in November, 1934.

Dr. Woodhouse was active in civic affairs, and served on the staffs of the Paul Kimball Hospital, Lakewood, and the Beach Boro's Hospital, Point Pleasant.

THE WOMAN'S AUXILIARY

GREETINGS TO THE WOMAN'S AUXILIARY

By Mrs. Frederick A. Kinch, President, Westfield, N. J.

The Summer is on the wane, Fall fast approaches, and the dawn of a new year is upon us for work and activity in our Auxiliary.

We hope you are refreshed and rejuvenated by an enjoyable vacation, whether it has consisted in listening to the lap or the roar of the ocean's waves, or viewing this vast country from mountain tops, or seeing the mighty cataracts, rushing mountain streams and the babbling brooks of the meadows, or sailing the ocean blue. Any of these diversions will fill your minds with brilliant ideas and recuperate your bodies to carry them forward for the year's work.

The convention of the American Medical Association at Atlantic City in June is a very pleasant memory. Its success was due to the untiring efforts of the excellent committees and the loyal support they had from the members of Delaware, Pennsylvania, and New Jersey.

In behalf of the State of New Jersey, we take this opportunity to express our appreciation and thanks to all personnel of the several committees and members of the Auxiliary. Too much cannot be said of the enthusiastic and unceasing work of these committees in looking after the minutest detail to make the guests of the convention happy and comfortable. Anything we can say inadequately expresses how grateful your President is to each and every one who helped to make these meetings a delightful and enjoyable remembrance.

The Fall Board Meeting of the Auxiliary will be held in October, and we hope to have the President of the New Jersey State Medical Society with us. At this meeting we will discuss plans for the work of the year, as laid out by the National Committee Chairmen and the recommendations of the National Board.

The growth and success of the Auxiliary depends on the coöperation of all of its officers, committees and members. With this end in view we look forward to the work of the coming year.

It will be highly gratifying when every County has an Auxiliary. Since our Annual Meeting in June one has been organized in Middlesex County. We also would like to increase the membership. Will every member of the Auxiliary consider herself one of a committee to further this object?

Quoting from a letter of Mrs. Robert W. Tomlinson, Wilmington, Del., President of the National Auxiliary, in the A. M. A. Bulletin, June, 1935, page 92:

"To those women who are not members of the Auxiliary, I commend more highly than anything else the friendships gained through its members, the understanding of association with them, and the opportunity to be of service to the highest of professions. The Auxiliary extends to you its greeting and its cordial invitation not only to become a member, but share in its delightful programs and events."

AUXILIARY ACTIVITIES

Dates of Meetings.—This is the season when the Woman's Auxiliaries to the several County Medical Societies will renew their activities. The dates of the meetings of most Auxiliaries coincide with those of the County Societies. A list of the dates for the year is printed on page 560 of this Journal. Preserve this list as a reminder not only to yourself, but also to your husbands and fathers who will attend the doctors' meeting.

Speakers' Bureau.—Read the editorial entitled "Projects of the Woman's Auxiliary" on page 510 of this issue of The Journal, calling attention to the Speakers' Bureau, and the opportunities which it presents to both the Auxiliary and the Medical Society. Also consult the *Advisory Committee to the Woman's Auxiliary,* whose personnel is listed on page IV of this Journal. Dr. Sprague and his associates are ready to advise any Auxiliary regarding the methods of enlisting members of your County Society to address lay audiences on public health topics. You make the dates with the women's organizations, and members of the Medical Society will be assigned to address the audiences.

Which Auxiliary will be the first to initiate this project?

Essex County

Reported by Mrs. Don Epler

The *Woman's Auxiliary to the Essex County Medical Society* held a luncheon meeting on , with one hundred and twelve members present. The following officers of the State Auxiliary were present as honored guests:

Mrs. Frederick A. Kinch, Westfield, President
Mrs. George Culver, Jersey City, Second Vice-President
Mrs. William A. Freile, Jersey City, Third Vice-President
Mrs. Edward W. Clarke, West Englewood, Director
Mrs. Frank P. Nicholson, Jersey City, Chairman of Publicity and Reporter
Mrs. John Nevin, Jersey City.

There were also present the following Presidents of neighboring Auxiliaries:

Mrs. A. E. Jaffin, Hudson County
Mrs. A. W. Bickner, Bergen County

ELECTION OF OFFICERS

The Committee on Nominations, Mrs. Sidney Keller, Chairman, present the following names for election:

Mrs. K. F. Forsyth, President
Mrs. F. G. Shaul, President-Elect
Mrs. Charles Zehnder, Vice-President
Mrs. Anthony Ambrose, Recording Secretary
Mrs. H. J. F. Wallhauser, Treasurer
Mrs. William Minningham, Director for 2 years
Mrs. Lyndon Peer, Director for 3 years
Mrs. Joseph Swirsky, Director for 3 years.

These officers were unanimously elected, and were installed by the President, Mrs. Don Epler, with an appropriate word of advice to each.

The retiring President, Mrs. Don Epler, was presented with flowers and a County President's Pin by Mrs. Theodore Teimer in an inspiring address commenting on the opportunities to form enduring friendships and render useful service.

ADDRESS BY THE PRESIDENT

Mrs. Epler, the retiring President, gave the following summary of the year's work:

The Woman's Auxiliary to the Essex County Medical Society has an active membership of 221 members. There have been two resignations due to illness, and one deceased member. As President, I presided over eight Board meetings, one Executive Committee meeting,—the first time our Executive Committee has functioned,—and committee meetings too many to mention. I have written numerous letters, and have become quite competent as a telephone operator.

I have kept in close contact with all officers and chairmen. As your representative I have attended all State Auxiliary meetings, also meeting with the Board of Health of Newark, East Orange Board of Health, and the Public Health Committee of Essex County Medical Society. Visits to our neighbors in nearby counties have afforded me a great deal of pleasure. The more I see of neighboring Auxiliary members the better I like them.

Our Auxiliary functions through the following committees: Program, Membership, Public Health, Public Relations, Ways and Means, Social, Legislature, Widows and Orphans, Press and Publication, Printing, and Telephone, and also a Historian.

The outstanding achievements of 1934-1935 have been stressed through our Public Health affiliations.

After our Reciprocity Meeting, contact was made with Miss Harriet Stone, Supervisor of Nutrition of the Board of Education, who recommended that this work be followed up by our successors. We have introduced a few new ideas—adopting a set of colors, royal blue and gold; and a die for our stationery, the drawing for which was done by one of our member's daughters, Carolyn Teimer. You will agree that the die adds to the appearance of our notices.

We also worked to have membership cards for next year, and Penny Envelopes printed to be used for our Benevolent Fund.

The Constitution has been printed in booklet form.

We purchased a tally tabulator, which was put to good use at our Reciprocity Meeting when we had an attendance of over 496 persons, and Dr. Martin E. Rehfuss spoke on the subject "Dietary Fadism".

The Auxiliary paid for decorating a room at the Academy of Medicine. The Auxiliary also paid the expenses incurred for the party at the Academy of Medicine in March. We also sent an extra contribution of $10.00 to the C. M. A. Fund.

The present Auxiliary Administration feels that interest in the educational work of our Auxiliary will be stimulated if every member will get in the habit of reading the Auxiliary pages in the A. M A. Bulletin, and the reports in our own State Journal. Under the advice of our Advisory Committee, it is our desire that our women assume leadership in promoting health programs and health projects in other women's organizations to which they belong in order to keep the doctor's viewpoint in the eyes of the public. The project of the *Speakers' Bureau* is the most important one which we can promote.

The social activities of our Auxiliary have given an opportunity to the members to share in the fellowship of service and culture which is ours.

We served as hostesses for our Supper Dance, and at the twenty-fourth Annual Meeting of the Academy of Medicine, also for the Essex County Tuberculosis League at the Essex Mountain Sanitarium. The chairmen of all committees have done splendid work in furthering the aims of the Auxiliary and acting as a union between the Medical Profession and the laity.

The meeting closed with a musical program.

Artists: Gladys Fraissinet, soprano; Mrs. Irving Fort, accompanist; Lillian Bellow Hayman, pianist.



SLEEP

"Sleep, mildest of all the gods, thou art thyself sweet peace of mind, a soothing balm, an alien to care, and brightest rest and strength to mortals worn and weary with the toils of life."

—OVID

IN troubled mind or weakened body, sleep has ever been Nature's own restorer. The quiet halt of sleep alone can yield a sound retreat from mental unrest, from the fretful thoughts which plague the mind in time of stress. It affords that pause during which the physiologic forces are directed toward the rehabilitation of the worn or diseased body. Without it, the best of therapeutic efforts may often go awry. Yet many times when sleep is needed most, the patient frets himself into a frantic wakefulness. It is here that the induction of sleep may be vitally important. When the physician desires a mild hypnotic action, relatively free from side-actions which might complicate the function of recovery, Ortal Sodium may be employed; its action is prompt, and the dosage can be regulated to provide the proper degree of sedative or hypnotic action, according to individual requirements.

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ANNUAL MEETING, JUNE 2-4, 1936, IN ATLANTIC CITY

THE JOURNAL

OF

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(*A chemical combination of calcium and creosote)

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NEWARK, NEW JERSEY

A Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous, or stupid at school.

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THE JOURNAL
OF
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Under the
Direction of the
Committee on Publication

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Executive Officer—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

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EDITORIALS

Constructive Action

The sick universally excite the deepest sympathy which often submerges the dictates of reason. The virtue of charity is naturally inherent in every person, and is expressed according to the natural trend of his thoughts. The doctor expresses his sympathy by the quiet distribution of his best personal services in the privacy of the homes of the sick and in the secluded wards and operating rooms of hospitals where publicity is a mortal sin. His most satisfactory reward for his whole-hearted response to calls under the most trying conditions is his own consciousness of having given the most exacting service rendered only in the presence of his assistants who share his unpenetrable reticence.

At the opposite extreme are the great "foundations" whose very existence depends on wide publicity of their motives and their claims of credit for the accomplishments of their hired agents, who are featured as "Angels of Mercy". The impression which they seek to convey is that it is their organization which makes possible the delivery of the essential services of the physician to a large proportion of suffering humanity.

The truth lies between the two extremes of the reticence of the physician and the exaggerated publicity of the professional welfare worker. Members of medical societies are becoming increasingly aware of the necessity that their societies shall reclaim the leadership which they have allowed the welfare workers to assume. The American Medical Association has listed 161 such plans devised and operated by medical societies. (Journal, August, page 500.)

One of the most outstanding and efficient of all the demonstrations, that of the Medical-Dental Service Bureau of the District of Columbia, was investigated by a committee of The Medical Society of New Jersey, was approved by the Council of the Essex County Medical Society, and was considered at a meeting of the Essex Society on September 12 (page 622). Its adoption by the medical societies of Newark, St. Louis, and a few other centers will be an efficient answer to the charge that the medical profession either cannot or will not devise and operate a plan for the equitable distribution of medical services.

The Physician and Safety

A striking characteristic of Governor Hoffman's Conference on Safety, which is described on page 618, was the prominence given to the medical profession, about one-quarter of the proceedings being given over to the State Department of Health. The Governor very properly considered that protection against infectious diseases came under the general head of measures for the protection of life and health.

Emphasis was placed on protective measures to be taken in the home against hazards such as those of fire, electricity, weak stepladders, and slippery floors.

Little was said about the responsibility of parents in the spread of contagious diseases. A passing reference was made to the child that has a contagious disease in a form so mild that the mother does not call a physician for fear she will be quarantined. This condition is particularly applicable to scarlet fever, for it is likely to run in a chain of cases, which are infected in a series. The first case is so mild that it is unrecognized; the second is detected only after the third and fourth cases of the series come down with a severe form of the disease, which becomes less severe in the succeeding cases until the chain of infection disappears in the sixth of the series.

There is a great need for arousing the conscience of parents against concealing their suspicions that a child may have scarlet fever or other contagious diseases.

Dates of Taking Office

The dates on which officers of county societies assume their duties was discussed during the Conference of County Secretaries and Reporters on November 7, 1934, and the sentiment was strongly in favor of making them conform to those of the officers of the State Society, which begin at the close of the annual meeting. An editorial appeal was made to the officers of the County Societies in The Journal of December, 1934.

To change the date of assuming office will usually involve an amendment to the constitution of the County Society. Eleven societies hold their annual meetings in October, three in November, and four in December. It is hoped that the County Societies will take action in order that the terms of the officers and committeemen shall begin at the close of the Annual Meeting of the State Society. Some have already done so.

Courtesy Use of Hospitals

As straws show which way the wind blows, so small changes of hospital policy are particularly significant and praiseworthy when they show a wind blowing in the direction of generous, broadminded consideration for fellow physicians.

Recently, two Essex County Hospitals, the Essex County Isolation Hospital, and the Mountainside Hospital of Montclair, have extended the privileges of caring for private and semi-private patients to a large group of physicians who had not previously enjoyed the favor of these institutions. The opportunity to care for patients in these hospitals was extended to members of the staffs of the other hospitals in the County that are approved by the American Medical Association or the College of Surgeons, provided that the individual is a member of his County Society.

This is a fine action deserving commendation. It recognizes that the medical profession, as exemplified by the physicians and surgeons on the staffs of hospitals, has a high general standard, and that the method of appointing these physicians to the hospital staffs depends on the ability of the physician as judged by his fellows who are closest to him. It points out the importance of membership

in organized medicine where the individual physician is obligated to maintain the high standards set by his fellows, and be subject to approval and discipline by them.

Should each hospital extend such courtesy privileges to the staff members of the other hospitals, it would allow a large group of competent physicians a free choice of the hospital in which to work, consistent with our aim that our patients should have free choice of their physician.

The judgment of a man's ability is placed directly with his fellow-workers in his own home hospital,—those who know him best. They will then be even more conscious of responsibility when the circle of those who respect and follow their judgment is extended. Other hospitals respectful of their judgment, willingly accept it, assured that it is considerate, right, and deliberate.

Another evidence is supplied that medicine is becoming more and more a true fraternity, with its members holding one another in high mutual regard; and at the same time is increasing its strength as these bonds of regard and affection between the different members of the family are strengthened.

Assurance of courtesies and privileges in neighboring hospitals might have an effect on those who hold multiple places on different hospital staffs just to insure that each hospital will be open to their patients. If they were assured that their ability would be recognized by several hospitals by virtue of their position in one, duplication of a position would become unnecessary, and they could resign some of their posts, thus allowing other men to secure advancement.

Such a reciprocal policy offers to hospital staffs a method of extending the courtesy of their hospital that is not dependent upon local favoritism, but will broaden contacts and associations for the mutual benefit of both the host and the visitor.

Earl LeRoy Wood.

The Field of the E. R. A.

The very readable report on the survey of 10,000 families on relief, which is reviewed on page 616, reveals the importance of medical conditions as a cause of economic dependency. One-quarter of the family heads on relief were in a crippled condition and were living at home. This condition existed before the E. R. A. was instituted, and will continue after the return of prosperity.

The experience of the E. R. A. has been an education to both physicians and welfare officials, and will point the way to an honorable method of treating those whom physical conditions have made dependent. It is noticeable that the words pauper, poor, and charity do not appear in the report, the words dependent, welfare, and economics being used in their place.

Interest in County Society Meetings

A County Medical Society assembled in a meeting is a living personality with a brain that thinks, eyes that see, ears that hear, a voice that speaks, hands that act, a face with smiles or frowns, and a demeanor and carriage of strength or lassitude. It is subject to fits of caprice and lethargy, which are functional rather than organic and readily yield to preventive suggestion and treatment. It is essentially sound in health, and ready to respond to wise leadership.

The members of the staff of The Medical Society of New Jersey are often consulted regarding the treatment of ills and the promotion of the vigor of county societies. Here are some prescriptions, all of which are readily available in the medicine closet of every society:

1. Open and close the meeting at the time announced on the program. Visitors and speakers as well as the members will take this prescription eagerly.

2. Appoint a standing "Business" or Executive Committee which will meet half an hour before the society meeting to prepare a brief report and opinion on essential matters to be considered by the Society.

3. Prepare a scientific program to consist of:

a. A medical speaker, to whom is assigned a half hour of time, with another half hour for open discussion. If speakers still wish to talk, let them express their opinions to willing listeners *after* the meeting closes.

b. An "exchange" speaker, to present the point of view of agencies engaged in community projects having a health implication. Assign fifteen minutes to the speaker, and fifteen to a discussion from the floor.

4. Assign fifteen minutes for suggestions by members "for the good of the profession".

5. Close the formal meeting promptly at the time appointed.

6. Serve simple refreshments under whose stimulus the members will talk together, thereby clarifying their impressions, and cementing their friendships.

A meeting conducted in this manner will have a force and attractiveness which will have a strong appeal to the members.

Functions and Organization of the State Society

The participants in a great movement are often unaware of the broad significance of their own work as they concentrate their attention on their own limited field of activity. A speaker at the opening meeting of Governor Hoffman's Conference on Safety on September 11, said, "Whatever New Jersey undertakes is done well." This remark applies with peculiar force to The Medical Society of New Jersey.

An attempt was made last Spring to construct a series of wall charts which should express the functions and organization of the Society with clearness and simplicity. An exhibition of these charts at the meeting of the American Medical Association elicited inquiries from visitors from all over the United States regarding the features which contributed to the recognized efficiency of the State Society and its component County Societies. A detailed analysis was therefore made of those methods of the Society which had a peculiar significance as compared with those of other State Societies. The result is the descriptive article which appears on page 607 of this Journal.

This study will help the members to clarify and classify their knowledge of the peculiar features of their own Society, even as it did that of the authors whose function is to interpret the methods and objectives of the organization. It will also indicate the lines along which the further development of the functions of the Society may be anticipated.

Equitable Free Service

Physicians have a dual responsibility,—a *personal* one to their private patients, and a *delegated* one to the community's indigents whom they serve as representatives of their Medical Society in accordance with agreements with other community welfare agencies.

The medical profession has always cared for the indigents in each community without charge. The growing abuse of this free service by non-indigent patients who are able, but unwilling, to pay for private medical service has been noted by physicians, and resentment against the abuse of such service is increasing. The growing demand for free medical services to be rendered as a part of the work of organizations whose other personnel receive financial rewards, is an unjust discrimination against the physician.

The members of the Medical Society are willing at all times to serve without charge in programs for the indigent whenever the other community workers contribute their services on the same volunteer basis.—L. A. W.

Teamwork

If each community organization or agency will keep well within the proper scope of the work for which it was founded, duplication of effort and omission of needed services will occur less frequently, and the community will be served more effectively and economically.

Improved distribution of medical service on an equitable basis will come about naturally in accordance with the unchangeable law of demand and supply. This demand must come from the *public itself*, and not alone from a few persons who presume to decide for the people.

No reasonable plan for enlisting widespread medical participation has ever been rejected by the Medical Society when such a plan has been developed with its coöperation. Such assistance is always obtainable on formal request sent to the Medical Society through the Executive Offices at 137 East State Street, Trenton, New Jersey, or made directly to the County Medical Society.

The Medical Society does not presume to dictate the plan; but as the best equipped community health agency available to provide medical service, the Society stands ready to aid in formulating and carrying out plans aimed to improve the health of the people.

A Health Council, composed of the officers of the important community agencies, can develop a desirable and effective plan to meet the most urgent needs at a fair cost. In such a plan the Medical Society members will do their part.

The greatest need is usually to select a capable executive to coördinate the available services, and keep the contributions within their legitimate scope.

One of the present difficulties lies in the fact that organizations founded for education, relief, and other specific purposes invade the field of medical service, with good intentions, but poor results. They should present their health service problems to the organized medical profession for study and for adaptation to accepted standards.

Perhaps we shall develop in the near future a "Forum" to discuss our problems and activities, and thus avoid duplication and omissions in the community plan and increase our efficiency and economy. Such efforts would help define and establish the proper scope of functions to be performed by each community group, and would provide the criteria by which the results may be properly judged.

These are times when each organization must rely on the results of its work to justify the expenditure of its funds. *Teamwork* is the keynote, and *The Medical Society of New Jersey* stands ready to do its part.—L. A. W.

The Legality of Professional Advertising

The medical and dental professions have common standards of advertising, although the mechanical nature of the dentist's ministrations is such that he can advertise with greater insinuation and impunity than the physician. Whereas a tooth might be valued at five or ten dollars, that of a finger or arm or leg, with which a physician deals, would be thousands of dollars, with a corresponding temptation for the patient to bring suit for alleged malpractice. Still the evils of dental advertising were so great and so widespread that in 1934 New Jersey enacted a law restraining dentists from advertising except by the simple display of a sign similar to that of a physician.

It might be difficult for a physician to state the grounds for the prohibition of advertising by physicians and dentists. Chief Justice Hughes of the Supreme Court of the United States has expressed the reasons clearly and concisely and in popular language, in formulating the unanimous decision of the court on April 1, 1935, in an appeal of a dentist in the State of Oregon from a decision of the highest court of the state denying the plaintiff the right of a dentist to advertise in a broadly commercial manner, in defiance of the Oregon law against such advertising. The basis of the appeal was that the Oregon law was unconstitutional in that it deprived the dentist of

his property rights in defiance of the Fourteenth Amendment to the Constitution of the United States.

The opinion is printed as an editorial in the Journal of the Medical Association of the State of Alabama, of July, 1935, page 14.

Justice Hughes first quoted the Oregon law relating to the practice of dentistry (Laws of Oregon, 1933, Chapter 166), in which at least twelve lines were devoted to an enumeration of the specific forms of advertising which a dentist could not use, and which are practically the same as those in the New Jersey law.

Justice Hughes then quoted extensively from the allegations of the plaintiff dentists that his claims of superior skill were based on fact, and that he had made extensive contracts for further advertising; and that a restriction of his advertising would ruin his business, and result in an unwarranted deprivation of his property rights. Justice Hughes said in his opinion:

"Plaintiff is not entitled to complain of interference with the contracts he describes, if the regulation of his conduct as a dentist is not an unreasonable exercise of the protective power of the State. His contracts were necessarily subject to that authority.

"Nor has plaintiff any ground for objection because the particular regulation is limited to dentists and is not extended to other professional classes. The State was not bound to deal alike with all these classes, or to strike at all evils at the sam time or in the same way. It could deal with the different professions according to the needs of the public in relation to each. We find no basis for the charge of an unconstitutional discrimination.

"The question is whether the challenged restrictions amount to an arbitrary interference with liberty and property, and thus violate the requirement of due process of law. That the State may regulate the practice of dentistry, prescribing the qualifications that are reasonably necessary, and to that end may require licenses and establish supervision by an administrative board, is not open to dispute. The State may thus afford protection against ignorance, incapacity and imposition. We have held that the State may deny to corporations the right to practise, insisting upon the personal obligations of individuals (Miller v. State Board of Dental Examincrs, 90 Colo. 193, 287 U. S. 563), and that it may prohibit advertising that tends to mislead the public in this respect. (Dr. Bloom. Dentist, Inc., v. Cruise, 259 N. Y. 358, 363; 288 U. S. 588.)

"Recognizing State power as to such matters, appellant insists that the statute in question goes too far because it prohibits advertising of the described character, although it may be truthful. He contends that the superiority he advertises exists in fact, that by his methods he is able to offer low prices and to render a beneficial public service contributing to the comfort and happiness of a large number of persons.

"The State court defined the policy of the statute. The court said that while, in itself, there was nothing harmful in merely advertising prices for dental work or in displaying glaring signs illustrating teeth and bridgework, it could not be doubted that practitioners who were not willing to abide by the ethics of their profession often resorted to such advertising methods 'to lure the credulous and ignorant members of the public to their offices for the purpose of fleecing them'. The Legislature was aiming at 'bait advertising'. 'Inducing patronage', said the court, 'by representations of "painless dentistry", "professional superiority", "free examinations", and "guaranteed" dental work was, as a general rule, the practice of the charlatan and the quack to entice the public.'

"We do not doubt the authority of the State to estimate the baleful effects of such methods and to put a stop to them. The Legislature was not dealing with traders in commodities, but with the vital interest of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the market-place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practioners, but protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous. What is generally called the 'ethics' of the profession is but the consensus of expert opinion as to the necessity of such standards.

"It is no answer to say, as regards appellant's claim of right to advertise his 'professional superiority' or his 'performance of professional services in a superior manner', that he is telling the truth. In framing its policy the Legislature was not bound to provide for determinations of the relative proficiency of particular practitioners. The Legislature was entitled to consider the general effects of the practices which it described, and if these effects were injurious in facilitating unwarranted and misleading claims, to counteract them by a general rule even though in particular instances there might be no actual deception or misstatement.

"The Judgement is affirmed."

This decision contains arguments which every physician may use in instructing the people regarding the laws upholding the professional ethics of the medical profession.

ORIGINAL ARTICLES

PHYSIOLOGICAL REST OF THE NOSE

AN UNRECOGNIZED FACTOR IN THE TREATMENT OF UPPER RESPIRATORY INFECTIONS

By Earl LeRoy Wood, M.D., M.Sc. (Med.), F.A.C.S., Newark, N. J.

Read May 1, 1935, before the General Session of the Annual Meeting of The Medical Society of New Jersey at Atlantic City

The treatment of upper respiratory infections,—the common cold and its sequellae, sinusitis, otitis media, etc.,—has attracted such widespread and extensive attention that almost every possible idea has been offered for benefit and cure. The intensive search for a cure continues, and a new approach to it is here offered. When I say a new approach, I mean a new application of a principle that is very old, old as medicine itself. It is the principle of *physiological rest*. This time-tested method of treatment has never before been consciously used or suggested as applicable to the nose, and is a new principle of treatment of upper respiratory infections.

It seems logical that we should look in the realm of physiology for benefit, especially since the pathological and bacteriological investigations have been so disappointing. In a better understanding of the physiology of the affected parts may lie the secret of prevention and cure. Of recent years there has been considerable important investigation of the physiology of the nose, especially of its defense and reparative processes.

Quickly reviewing recent opinions about nose physiology, we find that the normal membrane of the nose and sinuses has a succession of defensive and reparative forces. The first is a constantly moving film or blanket of *mucus* which forms an intact covering over the whole mucous membrane of the nose and sinuses, and which enmeshes such invaders as atmospheric dust and microörganisms.

The second factor is the *cilia* of the surface epithelia which tirelessly lash the mucous layer, propelling it from the furthermost sinus recess toward and through the ostium into the nasal cavity. There the same mechanism, these actively vibrating cilia, moves the secretion into the nasopharynx, whence it passes into the stomach.

The third factor in defense and recovery is the *connective tissue* layer with its capillaries, giving rise to those protective cells, called by Fenton[1] *histiocytes,* which are the phagocytic fixed cells of connective tissue.

These surface mechanisms, the mucus secretions and the cilia, have been extensively studied by such workers as J. Gray,[2] Leonard Hill,[3] Loundes Yates,[4] Hilding of the Mayo Clinic,[5] Arthur Proetz,[6] Victor Negus in London,[7] Lucas in St. Louis,[8] to name a few. There is a host of others equally prominent.

The *hydrogenion concentration* of the secretions has been determined in various conditions.[9, 10, 11] The activity of the cilia has been observed, tested, and photographed under the influence of various physical, chemical and bacteriological agents,[12] in vitro and vivo, in a state of nerve stimulation and paralysis,[13] and under the influence of drugs applied locally or injected into the blood stream. From all of this much knowledge has been acquired.

It is agreed that the normal mucosa, with functioning vibrating cilia surmounted by an intact blanket of mucus of normal viscosity, is a protective barrier impervious to virulent bacteria, vira, or pathogens of any type causing upper respiratory infections. The normal nose is just as efficiently protected against infection as is the rest of our body protected by the intact normal skin. An upset of this protective mechanism is a necessary preliminary to invasion by infection,[14] and after invasion the sooner normally functioning mucosa can be restored, the sooner disease will be controlled. The local method of treatment should

be beneficial to the normal mechanism with which the nose is naturally endowed. The reparative processes are capable, even after surgical exenteration of the sinuses, of restoring normal ciliated mucous membrane instead of non-functioning scar tissue,[15, 16, 17, 18] a fact which has proved to be most consoling to the sinus surgeon and helpful to the patient.

Diet theories about the cause and cure of sinus disease are unproven.[19] Dependence upon the acid-alkali relationship associated with the septal "color index" has been disappointing.[20]

In addition to the defensive and reparative mechanism just reviewed, and to the passive olfactory function of the nose, is the *active* function; namely, to warm, moisten, and filter the inspired air, delivering to the lungs an unvarying standard quality of air,—in other words, receiving air of practically any quality and adapting it to conform with a physiologically ideal standard before it enters the trachea.

The inspired air, after it passed through the nose, should have a *temperature* close to that of the body, should be purified of physical contamination and saturated with moisture. This is accomplished by the *turbinate bodies* which project into the nasal lumen from the lateral wall, a series of baffle plates around and between which passes the air, becoming altered in character from contact with these turbinate bodies. The turbinates increase or decrease in size, become more filled or less filled with blood, secrete less or more mucus, vary their size and activity, as necessitated by the nature of the surrounding atmosphere.

Of all the vital substances upon which life depends,—food, drink, and air,—none is so varied in its qualities as the air we breathe. Food and drink are standardized and subject to relatively little variation compared with the atmosphere in which we live. Yet the diseased nose, which now concerns us, is expected to receive any variety of air, and to deliver to the lungs one unvarying standard quality. Thus pictured, the nose is seen as an organ with a very active function. Like other organs when diseased, the ability to function is impaired; and if it is physiologically rested, more attention can be devoted to the defensive and reparative process in overcoming the infection.

Outside of those few diseases for which we have specific cures, we depend for the most part on our *natural reparative processes* to bring about recovery. To assist this we try to make the surrounding circumstances most conducive to this recovery.

REST

One great therapeutic aid which man has thus used since the beginning of time is *rest,* both physical and physiological. It is needless to recall to your mind all the different applications of therapeutic rest. They are legion, time-honored and mostly of a value beyond dispute; such as general body rest, immobilization of the damaged limb, etc. It is not impossible, however, to find new applications of this old established principle. Quite recently our own Dr. Eagleton[21] offered a new application of rest by the ligation of the carotid artery in the treatment of intra-cranial disease, thus resting the neighboring parts from the artery's continual pulsation. The benefit of physiological rest is recalled with equally familiar examples, as vocal rest for the diseased larynx, and darkened rooms for diseased eyes; and also phrenecotomy in tuberculosis, which is another recent suggestion. In nephritis, excretion is stimulated from other organs to relieve the burden on the diseased kidney. The work of the diseased alimentary tract is lightened by giving food that is predigested or requires little digestion. This same principle may be applied to the upper respiratory tract.

The physiological burden can be relieved, and the nose can be physiologically splinted, so to speak, by supplying for inspiration, an air that is already warmed, saturated with moisture, purified, free from dust particles, an air that is subject to very slight variations of temperature and character during the twenty-four hours. Little or no alteration of such an inspired air will be necessary, less function will be demanded, and the nose will be in a state of physiological rest,—the condition, in general, most favorable for any organ to recover from disease. Assistance will be lent to the defense and reparative mechanism with which the nose it naturally endowed.

INFLUENTIAL FACTORS

While functional rest for the nose in the treatment of nasal inflammations seems simple and fundamental, one should hesitate to attach importance to it without careful scrutiny of the evidence that atmospheric factors are really influential. The following queries naturally arise:

1. Is variability of temperature a factor in the incidence of colds?

2. Is a moist air more healthful than a dry air?

3. Is there any evidence that abuse of the physiological function of the nasal passages does result in an exhaustion, or incompetence to function normally?

Upon examination, I have found an abundance of evidence that the answers to all these questions are in the affirmative.

TEMPERATURE

First let us consider the influence of temperature on the incidence of respiratory infections. This is practically admitted by all who have made observations. Remarkable agreement is shown between the inverse temperature curve of the air and the curve for upper respiratory disease. There is a direct and proportionate increase of respiratory disease as the temperature falls, and a decrease as the temperature rises. Lierle[22] attributed to variable climate the prevalence of sinus disease in infants, considering it the underlying cause. Goldsmith[23] was certain that chilling is a big factor in stirring up acute sinusitis due to exposure. Condemning sudden changes of temperature, chilling and a variable climate, Barnhill[24] concluded: "The most valued features of any climate in so far as they relate to benefit of respiratory infections are mildness and freedom from marked changes of temperature from midday to midnight." Kirsch[25] felt so strongly that variability is a paramount factor in the incidence of colds that in order to assure children an equability of temperature, he advised that they be kept out-of-doors all the time, day and night. He rightly blamed what he called the *"Domestikationsfaktor"* for the occurrence of the winter peak of the disease. Woolen,[26] Klemperer,[27] Collet[28] are of the opinion that variability is the exciting cause of "colds", the chilling of the body surface producing a vasomotor reaction in the nasal cavity.[29]

The deleterious effect of variability of temperature has been proved by experimenting with lower forms of life. A study of the larvae of the webbing clothes moth and of the black carpet beetle[30] has revealed that it is not so much the cold which kills, as it is the sudden change from a cold to a warmer temperature and back again to a cold temperature. Thus it was deduced that if articles infected with clothes moths were refrigerated at 18° F. for several days, then suddenly exposed for a short time to 50°, then returned to 18° and finally held permanently at about 40°, all moth life in them would be killed. Rabbits[31] kept at 70° F. and then chilled to 20°-50° or chilled first and kept at 70° are much more susceptible to infection than animals kept in an even temperature of 65° to 70° F. Thus, statistical, clinical and experimental evidence all indicate that variability of temperature is a great factor in the incidence of disease; and conversely, equability is encouraging to health.

MOISTURE

We now come to the second factor, namely, moisture. Is moist air more healthful than dry air? Contrary to much common opinion, it has been shown to be. Lederer[32] observed that dry periods of fine weather were followed by a high incidence of disease even in winter. Huntington[33] conducted a world-wide survey of the relation of climate to health, particularly stressing the influence of moist and dry air. Basing his facts on the records of nearly nine million deaths and the official figures of weather bureaus, he demonstrated that dry weather increases the death rate. The most favorable temperatures have a fairly high degree of moisture—a relative humidity of about 80 per cent for day and night. Huntington compared statistics obtainable for dry Januaries with those of the wet Januaries of the same temperatures at specific places, such as New York, Chicago, San Francisco, or elsewhere, and found that the dry months were systematically

less healthful. The same was true for the wet and dry Februaries and Marches.

For upper respiratory diseases a dry climate is *less* beneficial than a moist one. Analysis of the postoperative death rate in Boston in relation to humidity and temperature showed dry days to be more harmful than moist days. From all over the world death rates appear generally to be higher in dry regions than in moist ones. On the basis of the deaths in Paris from 1904 to 1913, Besson,[34] the chief of the *Service Physique et Météorologique,* has come to this conclusion: "On the whole, when the humidity increases, the mortality from diseases of the respiratory organs decreases two or three weeks later."

Huntington's description of the benefits of a change from dry to moist weather in India is so graphic that it is worth quoting at length:

"The most important effect of the monsoon is the rain. In winter only the southern tip of India gets much rain, for that is the only part of the country where the northeast trades blow from the sea to the land. Elsewhere drought prevails, month after month, and the people long for the summer monsoon. Before it comes the air is burning hot, then the southwest wind begins to blow, the clouds gather, the sky is full of lightning, the thunder crashes, rain falls, and the air is cooled, and the people welcome the rains with feasting and rejoicing. Contrary to the usual belief, the summer monsoon rains restore the health of the sick, check epidemics, and bring the most healthful part of the year." [35]

EXHAUSTION OF FUNCTION

Lastly, is there evidence that abuse of the physiological function of the nose results in an exhaustion, or lack of function? Hilding's[36] experiments indicate clearly that the nasal mucosa has an adaptable property of radically altering its form in a comparatively short time according to the demands made upon it. It may be said that, under normal circumstances, there is a complete new lining formed over all the ciliated areas every ten or fifteen minutes, and prolific regeneration seems to be a part of the physiologic process. When its capabilities are over-taxed, the epithelium of the membrane is altered from a ciliated columnar to a squamous-like form; and it ceases its tremendous activity and becomes passively resistant and inert. There is a *physiological collapse* and now all its powers of resistance to infection become latent and it is susceptible to almost any pathogen. Thus, there has occurred the physiological collapse which precedes disease.

COMMENT

An atmosphere affording physiological rest of the upper respiratory apparatus is not necessarily recommended for constant living, but rather for the correction of defects and errors. Just as splinting cures a broken limb, but does not strengthen a normal one, so respiratory organs suffering from the results of infection may be benefited by equable, warm, moist air which the normal nose does not necessarily require. Physiological rest of the respiratory organs involves the reduction of the functional burden by supplying an air which is nearer the physiological ideal, and which does not force the nose to adapt itself to so many changing and extremely different conditions. This atmosphere suited to promote recovery may be obtainable by the patient going to where such natural air abounds, or by altering the available air where he is, in order to conform with and approach the physiological ideal.

In my first remarks I said something about this being a new application of an established principle which had not been "consciously" used previously. When our patients suffering from intractable upper respiratory trouble during the winter months derive benefit from a visit to the southern seacoast, we should recognize that the benefit is due to physiological rest.

Unfortunately, each sufferer cannot go south for every cold during the winter, but much can be done for the stay-at-home. We can, in addition to general body rest, reduce the function of the nose by keeping the temperature of the patient's room as free as possible from variations. An ordinary room thermometer may be properly and conspicuously placed to serve as a guide. The temperature should not be allowed to rise to an extreme during the day, nor to fall at night, the fluctuation being confined to a narrow range. Dust and physical impurities in the air should be avoided. The air should be moistened to a high humidity.

Modern systems of *air conditioning* are distinctly advantageous and should be encouraged

for hospitals, but are rarely available for the individual sick room at home. There, all methods of putting *more moisture* into the air are helpful. Moist cloths may be suspended over hot radiators. The simple method of keeping one or more kettles or pans of water actively and constantly boiling near the patient's bedside is quite effective.

A simple test of room humidity during the winter months is the condensation on the window glass. When the outdoor temperature is 40° F. or below, as it is mostly during our winters (Newark, N. J.), the humidity inside is too low unless there is some condensation or "steam" on the pane of the ordinary window.

In conclusion, it is suggested that upper respiratory infections be treated in this manner in addition to whatever else you wish to do for them, so that the patient may receive what local benefit may accrue from physiological rest of the diseased part.

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EVOLUTION OR REVOLUTION IN MEDICAL METHODS

By ARTHUR C. CHRISTIE, M.D., Washington, D. C.

Abstract of an address given on September 12, 1935, by invitation, before the Essex County Medical Society, Newark, N. J.

The best way to solve social questions is step by step, through a natural extension of existing methods and habits of thought. It is utterly impossible to make up a new scheme of social action that will work out with even reasonable satisfaction, for every new plan involves human personalities with various and even contradictory ideals and opinions. A new social experiment that is once put into operation cannot be discarded and another one set up, as in a chemical laboratory, for its memory remains as dregs in the social retort.

The fundamental methods of delivering medical services have been slowly adapted to human needs through centuries of experience; but during the past five years the sudden depression in economic conditions have called forth equally rapid suggestions for changes that are revolutionary and catastrophic, rather than a natural adaptation of old methods to new conditions.

The physicians and dentists of the City of Washington, D. C., have evolved a plan whose essential feature is the *coöperation* of existing agencies under the direction and control of the Medical and Dental Professions. The only new agency or method that was introduced was the Medical-Dental Service Bureau, which served not only physicians and dentists, but also the hospitals and the welfare and social agencies having contacts with the sick. The Bureau secures the coöperation of all the agencies that are concerned with the particular case that is referred to it.

SICKNESS INSURANCE

The Washington plan for the *coördination* of all services to the sick has a great competitor in the proposal for the *insurance* of medical care, to be either *voluntary* or *compulsory* on the part of the patient.

The defect in the appeal of sickness insurance to *the individual person,* is that it deals with an unpleasant contingency which he strongly prefers to ignore as impossible.

In contrast with insurance, the plan of payment by *installments* makes a strong appeal in that the buyer has the use of the article or service immediately, and its loss produces discomfort at once. Philanthropists and politicians have a decided preference for insurance because it adopts the easy way of *mass action,* and avoids the more difficult method of *personal contacts* which is the characteristic of the present system of the practice of medicine.

Physicians generally are opposed to sickness insurance, but the weakness of their position is that they have neither devised, nor actively promoted, a definite plan for the coördination of medical services. Still every physician should be prepared to expose the weakness of sickness insurance.

1. Experience demonstrates that the quality of medical practice deteriorates under sickness insurance. The quality of service of medicine to the insured in Germany, England, France, and the Scandanavian countries has fallen below the standards of practice among similar classes in the United States.

2. Insurance leads inevitably to the loss of the friendly relation of doctor to patient that has always characterized the practice of medicine. A sick person wants his own doctor,—and not one sent by the Government, or the insurance company, or even his fraternal lodge.

3. A successful plan of sickness insurance should *reduce* the amount of sickness among the insured. The fact is that while the average number of days of sickness per capita was seven at the beginning of the experiments, it increased to seventeen at the present time. The obvious reason is that the insured have demanded treatment for ills which were trivial or imaginary, or actually invented. Every doctor knows that malingering, either deliberate

or unconscious, is exceedingly common among neurotic patients who seek the stimulus of attention and sympathy.

4. While the mortality rate has decreased in countries that are under sickness insurance, it has fallen fifty per cent faster in the United States where sickness insurance has been almost unknown.

5. The argument of the business man is that the cost of care of the sick would be reduced under insurance. Experience has demonstrated that insurance has increased the costs, and for three reasons:

a. The increase in the number of patients who receive treatment.

b. The overhead cost of the administration of the services. The Epstein Bill on Social Security, which is to be introduced in the State Legislatures, sets up an elaborate bureaucracy in districts, counties, and municipalities, with salaried supervisors and inspectors everywhere.

c. Voluntary plans of sickness insurance break down because of the heavy cost of their administration. When a system of voluntary sickness insurance is installed under *a permissive law*, the government soon extends its *aid* under conditions which quickly become full *control* under *compulsion* with all its expenses and evils.

Physicians throughout the country are now faced with the necessity of making a choice between two systems of medical economics. First is that of mass business developed by the lay health organizations and endowed "foundations", beginning with voluntary insurance and ending with governmental control. This system has had wide publicity and the support of the executives in the Federal Government.

The second system is that proposed by groups of physicians, especially the State Medical Societies. Its feature is the coöperation of physicians with other organizations engaged in the services of health.

A criticism of the medical profession is that it has been slow to form plans, and reticent in publicity. But the Medical Society of the District of Columbia has developed and established what is known as the *Medical-Dental Service Bureau,* which is a complete answer to the challenge of governmental control. The project will be described to you tonight by Dr. Ross Garrett, the Director of the Bureau.

THE WASHINGTON, D. C., MEDICAL-DENTAL SERVICE BUREAU

THE MEDICAL ECONOMIC PROJECT OF THE PHYSICIANS AND DENTISTS OF THE DISTRICT OF COLUMBIA

By Ross Garrett, Dr. P.H., Director of the Bureau

Abstract of an address given by invitation before the Essex County Medical Society in Newark, on September 12, 1935

We humans grow up a little at a time. Up to 1929 the system of medical care functioned normally; and then all at once the machinery for the delivery of medical care began to function unsatisfactorily, like a good child who suddenly becomes unruly, to the dismay of his parents. When the child needs correction two methods are open to the father and mother:

1. They may be arbitrary and order a change in the youth's habits of action.

2. They may reason with the child, with the result that both the child and its parents revamp their ideas of their mutual relationship.

The medical and dental professions, the hospitals, and the administrative agencies, all are children of one family whose members minister to the sick. They might quarrel over the diagnosis and remedy; or they can reason together and each may adapt its habit of thought to the new conditions, and become once more a happy family with all its members coöperating with one another.

The United States had more money and more natural resources than any other nation; but in 1929 each of the several agencies engaged in the delivery of medical services became maladjusted and could not function; and a cry went up for a new system.

If a doctor's good automobile does not start on some morning when he is stalled on a crowded street, he does not call on Santa Claus to send him a new car; nor does he listen to suggestions of bystanders to get a new wheel, or to put the engine under the back seat. He goes to an experienced mechanic, who adjusts the disordered parts and restores the car to its former efficiency.

The machinery of medical and dental professions is as good as ever, but some of its parts need adjustment, or possibly the drivers need instruction.

MACHINERY FOR MEDICAL SERVICES

The modern machinery for the delivery of the services of medicine to the people has become exceedingly complex, especially in economic lines. Let us enumerate some of the agencies which impose burdens on the machinery of the medical and dental professions:

1. The patients who still expect efficient services, but are unable to pay for it.
2. Hospitals and dispensaries who compete with doctors in private practice.
3. Firms of employers who ask for medical and dental services for the employees.
4. The capitalists whose generous gifts support hospitals and welfare organiations.
5. Public agencies, such as schools, which demand physical examinations and immunizations for the pupils.

The ultimate supply of these demands falls upon the physicians and dentists, for they alone can legally make the actual delivery of the services of medicine. They have only one standard for their services, and that is the highest that science can supply. They are not tradesmen who have wares of various standards, and prices whose value can be accurately judged by those who buy them. The people expect the doctors and dentists to deliver services of the best quality no matter what price they pay, or whether or not they pay anything at all.

The existing machinery for the delivery of medical and dental services is adjusted on an economic basis to three classes of patients:

1. Those of independent means who can pay for all the services which they require.
2. Those who are independent except under abnormal conditions such as intense business depression, or crippling sickness which cuts off their incomes.
3. The indigent, who have been, and always will be, the wards of the public.

While times were prosperous, the patients in the independent class paid so abundantly that the doctors were able and willing to donate their services to the indigent and to those who were semi-independent; but the recent great increase in the number of those in these two classifications imposes on the doctors and dentists a burden that is inequitable, and unjust.

Most of the proposals for remedying these conditions have come from outside the two professions; but the practitioners of the District of Columbia have assumed the leadership in devising and putting into operation a plan by which all the services of medicine, direct and indirect, are operated and coördinated by one agency that is controlled by the medical and dental societies.

THE WASHINGTON PLAN FOR CO-ORDINATION OF THE RESOURCES OF MEDICAL CARE

The Washington plan was devised for the benefit of that great body of self-respecting citizens who need economic *advice* rather than *financial* assistance. A typical example of this class is a boy who needs relief from repeated attacks of tonsillitis. His father wishes to give his boy the benefit of a tonsillectomy, but he asks, "How much will the operation cost?", and says frankly, "I cannot afford it for I have not been able to save up the money to pay the doctor and the hospital." Yet the father will gladly make provision for the services if he is advised how he can do it.

The Washington Plan coördinates all the agencies,—medical, dental, hospital, social, welfare and fiscal,—so that they coöperate in rendering services which the semi-independent patient needs. The plan is as follows:

1. The incorporation of a non-profit organization called *The Medical Service Bureau,* whose members are physicians and dentists only.
2. The establishment of working headquarters in offices which are dignified and commodious.

3. The coöperation of hospitals, nursing groups, and welfare organizations, whose services are necessary for making investigations regarding the social and economic status of the applicants, and carrying out the business of the Bureau.

4. Advising the applicants as to how much they can afford to pay for the medical and dental services, and how they can pay it.

5. Collecting the fees in regular installments and paying them to the doctor or dentist.

The plan is not sickness insurance, which consist in collecting payments in advance for something which the insured may never need, —or at least he hopes so. It is a plan for enabling the patient to pay for services after they have been delivered to him on terms to which he voluntarily agrees.

THE OPERATION OF THE BUREAU

The actual operation of the Bureau is as follows:

1. The doctor called to a patient in the semi-independent class, sends him to the Bureau with a note of introduction.

2. The Bureau, through the coöperating welfare and social agencies, investigates and corroborates the economic status of the patient.

3. The Bureau consults the patient in a friendly way, and secures his consent to pay a certain sum every week or month to the Bureau toward liquidating his bill to the doctor, or dentist, or hospital. The charge is so adjusted that the bill will be paid within a year.

4. Ten per cent of the collections are retained by the Bureau and are allocated to the expenses of administration and to form a revolving fund which takes care of the patient if unexpected complications or new sickness prevents him from keeping up the payments.

5. If an applicant is found to be unable to make regular payments, he is referred to a social or governmental agency for relief.

THE SCOPE OF THE PLAN

The Bureau adapts the time-honored principles of the private practice of medicine and dentistry to new conditions, and is the answer of the physicians and dentists of Washington to the plans of the Government to assume control of the delivery of the services. If a number of cities adopt the plan, as St. Louis is ready to do, Congress will probably recognize its existence and will conform its legislation to the standards and methods established by the physicians and dentists of Washington.

In conclusion, let me distribute a mimeographed form of instructions to physicians and dentists issued under the auspices of The Medical Society of New Jersey.

INSTRUCTIONS FOR USING THE MEDICAL-DENTAL SERVICE BUREAU

1. Tell your patient or the one financially responsible for the patient that the Medical-Dental Service Bureau belongs to you as a member of your ethical society—that the Bureau helps to serve you and your patients in making financial arrangements.

2. Tell your patient that you are giving him a card of introduction, which you give only to patients in whom you have confidence.

3. Fill out the card of introduction—being sure to include on it the amount due for past services rendered by you and estimated amount of your fee or fees for services to *be* rendered.

4. Have your patient affix his signature to the card of introduction, in the space provided. This serves two purposes—it gives consent of diagnosis being given to the Bureau and it establishes the identity of the person as being the party purporting to be your patient when they signed with the Bureau, assuming responsibility for your fee.

5. On arriving at the Bureau, the economic status of the patient will be determined and corroborated.

6. The Bureau will advise you of your patient's financial picture and the maximum amount he is able to budget monthly for the purpose of paying for your services.

7. You will then determine any adjustments that you will deem wise to make in your fee or fees so as not to force the patient to be paying the maximum amount that his budget permits over too long a period of time; thus prohibiting his paying anything on additional medical hazards occurring during that long period.

8. In accordance with the fee or fees determined by you, the Bureau will have your patient or the one financially responsible, enter into an agreement whereby regular payments are to be made to the Bureau on your behalf.

9. An account card confirming the agreement entered into by the Bureau with your patient will be sent you or given to your patient to be delivered to you, if you so indicate.

10. Ninety per cent of all payments received by the Bureau from your patient during each calendar month will be mailed to you by check on or about the tenth of the month following that in which the payments were made.

THE TREATMENT OF BACKACHE FROM THE ORTHOPEDIC STANDPOINT

By Arthur J. Davidson, M.D., F.A.C.S., and Morris T. Horwitz, M.D.,
Philadelphia, Pa.

Read before the Atlantic County Medical Society, December 14th, 1934

It is impossible, except in a most lengthy discourse, to consider the treatment of backache from every etiological standpoint. But having delegated certain cases to the gynecologist, neurosurgeon, genito-urinary specialist, internist, and general surgeon, there are a number that essentially come within the realm of the orthopedic surgeon. These we may classify as:

1. Traumatic backache.
2. Infectious backache, including arthritis and tuberculosis.
3. Static or attitudinal backache.

1. TRAUMATIC BACKACHE

Rest is the most essential single agent of therapy in all backache cases, especially of the traumatic variety. Acute traumatic strains of the vertebral, sacro-iliac or lumbo-sacral joints, many of which involve muscular, fascial and ligamentous tears, are treated by rest in recumbency on a non-sagging mattress, pads beneath the lumbar spine in the lumbo-sacral case, beneath the knees in the sacro-iliac case, and by fixation with two- or three-inch-wide adhesive strips applied criss-cross from the axillary margins to the opposite thigh in the lumbo-sacral cases and about the ilia, completely encircling the body, in the sacro-iliac strains. This fixation may be preceded by some form of manipulation, either acute flexion of the thigh with the knee extended (Ryerson) or super-extension of the thigh (Ely), maneuvers not infrequently associated with a palpable and audible click and immediate relief. Physio-therapy, especially in the form of baking, is a most valuable adjunct. Movement is encouraged with the patient out of bed in two to three weeks. If continued support is felt necessary, following the removal of the adhesive strapping, a cloth corset or a light steel brace may be applied.

In the subacute or chronic, recurrent case, where there is not infrequently some basic anatomical variation or deficiency, where conservative therapy with external fixation, vigorous physiotherapy, and manipulation, under anesthesia, to break down adhesions, has been of no avail, and especially where secondary arthritic changes are beginning to appear, fusion or internal fixation is indicated ether by destructon of the joint at fault; i. e., an arthrodesis or by a transplanted bone graft in the manner of Albee. Not infrequently, where the sacro-iliac joint is involved and fused, it is found advantageous to obliterate also a weakened lumbo-sacral joint.

All cases where there is a likelihood of dislocation, dislocation-fracture or fracture of a vertebra, must be transported face-down, excessive motion carefully avoided, and neurological evidence of compression or hemorrhage anticipated.

The conservative plan of treatment of these cases is that of hyper-extension casting with traction as advocated by Davis in 1929, the basis of hyper-extension being not only the removal of pressure above and below the compressed fracture, but also that the traction of the anterior spinal ligaments pull the edges of the involved segment apart, the gap to become filled with osseous tissue.

The operative plan of internal fixation is indicated, first, in those cases associated with or followed by mechanical insufficencies, secondary local arthritis, progressive and intractible complaints, without relief by conservative measures of fixation, and second, in Kümmel's disease or traumatic spondylitis. The extirpation of a fractured transverse process or coccyx may bring instant relief. Intractable coccygodynia, of traumatic etiology in 80 per cent of cases, may be alleviated by injections of 10 to 15 minims of 80 per cent alcohol at the site of maximum tenderness, but removal of the coccyx is not infrequently the only measure of relief.

2. INFECTIOUS BACKACHE

a. ARTHRITIS OR SPONDYLITIS DEFORMANS

This may involve the vertebrae, lumbo-sacral or sacro-iliac joints, either primarily or as a part of a generalized arthritis deformans.

In the acute stage, one must resort to a careful medical regime—the removal of foci of infection, dietary control, careful elimination, sedative drugs, and specific or non-specific therapy, along with rest either in recumbency in the very acute cases or in ambulation, with adequate external support.

As the condition passes in to the subacute stage, electricity and baking may be supplemented by gentle massage, while in the quiescent stage, gentle exercises to loosen up the spine and improve the spinal musculature are to be encouraged and guided.

In the severe, intractable cases, one may utilize recumbency on a convex frame, with or without Buck's extension. Frequently, however, relief is not secured until the involved area is internally fixed either by fusion or by a bone graft. This measure will be found of value only in those cases where the arthritis is local, and should be resorted to where there are mechanical and anatomical or congenital deficiencies, with progressive and intractable symptoms, and where a conservative regime has failed.

b. TUBERCULOSIS

The three great principles in the treatment of tuberculosis spondylitis are:

1. To support the super-incumbent weight.
2. To make some form of posterior leverage to throw the weight of the upper body on the posterior and lateral segments of the spine.
3. To afford some form of fixation until ankylosis occurs. so that the arrest and healing of the diseased area may ensue.

Medical care and supervision with heliotherapy and a highly nutritious diet, are of prime importance.

The conservative plan of external fixation may be carried out in ambulation with casts or braces, or in recumbency with or without fixaton. The recumbent plan with external fixation is the most preferable conservative measure. However, the conservative plan is prolonged and tedious; fixation is expensive, readily broken or put out of order; there is a long period of incapacity of 4 to 5 years; and the results are rarely brilliant and deformity is often not prevented.

The operative plan of posterior spinal fixation or internal fixation, either by a Hibbs' fusion or an Albee tibial bone graft or one of their modifications, has been accepted by the medical profession, especially with the recent excellent statistical reports of Henderson, Allison, Hibbs and Albee, as the most advisable curative means in adults and older children. Its application in very young children is still controversial.

Sacro-iliac tuberculosis is the most fatal of all joint tuberculosis. The prognosis, generally poor, is most favorable when fusion operations are performed early. The conservative plan of recumbency with external fixation, either in a celluloid cast or double plaster spica, is usually inadequate. Operative fusion, the most satisfactory method of treatment, except in the advanced stage with abscess formation, where osseous fusion is less apt to occur, may be secured by extirpation of the diseased tissue and destruction of the joint by an arthrodesis, either in the method of Smith-Peterson or Gaenslen, or by an extra-articular bone graft, utilizing a portion of the iliac crest (Campbell), in which the joint is not entered and the likelihood of secondary infection removed.

3. STATIC OR ATTITUDINAL BACKACHE

Ninety per cent of all cases of backache are confined to those conditions in which symptoms are due chiefly to the wrong use of the part or faulty mechanics, the symptoms being due to strain with chronic weakness of the part.

Apparently the lumbo-sacral region is undergoing evolution in the human race and is the frequent seat of congenital and anatomical variation. These anomalies, as well as the mechanically insufficient pelvis, congenital or acquired, with exaggerated lumbar curve, weak and relaxed ligaments, and complicated by disturbanecs of weight and balance, are not of themselves causes of backache, but they predispose by their weakness and instability, to a sus-

ceptibility to strain and injury, and a traumatic arthritis is very apt to develop.

Conservative treatment consists of general nutritional care and external fixation and physio-therapy, in ambulation, or in recumbency in the very acute cases. With subsidence of the acute symptoms, massage, carefully guided exercises, and the correction of faulty posture and balance, with continued external support, must be carried out.

Operative measures are indicated where short heel and toe tendons must be tenotomized, and deformities or disease of the lower extremities corrected to restore balance. An impinging transverse process or a sacralized lateral process with local arthritis, may be removed with subsequent relief. Internal fixation is indicated where there are mechanical or anatomical deficiencies with progressive increasing symptoms, despite the conservative plan, especially in the presence of a developing local traumatic arthritis.

A word concerning the hyperaesthetic spine or "traumatic neurosis of the spine", a not infrequent type of case in legal and insurance work. The diagnosis must be made with utmost caution, and, if assured, the patient's mental status must be treated as carefully as though some organic derangement were present. Active physiotherapy, support, a careful dietary regime, and psychotherapy, i. e., suggestion, optimism and reëducation, may be utilized with varying success.

There is, also, a definite psychogenic element in all chronic backache cases who have suffered over a long period of time, and this factor must be given due consideration in order to enact a complete cure.

THE PAINFUL BACK

CLINICAL EXAMINATION AND DIAGNOSIS

By A. M. Rechtman, M.D., F.A.C.S., Philadelphia, Pa.

Presented at a meeting of the Atlantic County Medical Society, Atlantic City, N. J., December 14, 1934, in a Symposium on Backache

The chief complaints of most patients with low back pain are strikingly similar,—either pain after exertion, localized or referred, or pain and stiffness on change of position. The former suggests strain as being the chief cause, while the latter may indicate the effects of local irritation due to absorption from a distant focus of infection, upon an area potentially weak.

A detailed history is essential so as to evaluate the many factors which may be associated with back pain. A history of the beginning and not alone of the present attack may aid in a better understanding of the case, and often in the proper Roentgen ray interpretation. Frequently, more than one area may be affected, but the patient may refer his symptoms to only one part. Remember that the patient has not alone a back, the chief source of complaint, but many other parts which may be responsible for the backache.

The causes of backache are legion. If, on examination, the back appears anatomically and structurally normal, and the patient complains of back pain, the discomfort usually responds well to treatment and a recurrence of the pain is unusual. The etiological factor, if not traumatic, may be associated with some condition other than the back itself, which may add strain to the back and so cause the symptoms.

1. Pain in the back may, and often does, usher in the *acute infectious diseases,* hence the need for a detailed history, and a complete physical examination.

2. *Disturbances of Organs.* Certain disturbances of almost any of the intra-abdominal or intra-thoracic organs may be associated with backache. Time does permit only of mere mention of the back pain which may be associated with a disturbance of the gastro-intestinal, gall-bladder, genito-urinary, gynecological, or cardiac systems. The presence of these conditions, however, does not necessarily mean

that they are the cause of the back pain. It may be simpler and saner to note the effect of support, as by the use of a corset, on the symptoms of back pain than to subject the patient to intensive palliative or surgical treatment for a disturbance in some organ, if the treatment is directed primarily to relieve a backache.

Visceral pain may frequently be referred to the back. Irritation of the ilio-psoas muscle by an inflammatory lesion of the adnexa, or the appendix, lower rectal varicosities, or a rectal distension associated with chronic constipation may all cause backache. The patient assumes a strained attitude in an attempt to relax the muscle spasm; poor posture and its associated back symptoms may result.

3. *Injury,* mild or severe, may be associated with backache though the cause of the pain may not be essentially traumatic. A detailed history and examination may show a preexisting developmental spinal condition, or an infection, or an arthritis as the causative factor. Backache due to inury in a patient with a structurally normal back tends to recover. The presence of areas of focal infection, an arthritis, or a structurally potentially weak back may retard recovery and chronic backache may result. Laborers, after a slight injury, often suffer a prolonged back disability because the stress and strain of their work potentially lowers their resistance.

4. The rôle of *sepsis* and of *focal infection* in the etiology of backache is important, and is an associated cause of the discomfort of many patients with chronic or recurring attacks of back pain. Absorption from an area of focal infection may cause local irritation and induce muscle spasm, causing the weak back to become painful. Treating the areas of focal infection tends to prevent a recurrence of the backache. Pain and stiffness on change of position is very suggestive of local irritation which may be due to absorption from a distant focus.

The teeth, tonsils, and sinuses have been regarded as the chief sources of focal infection, possibly because they are readily investigated, and correction may not be difficult. If the bowels, gall-bladder, adnexa and other internal organs or parts are affected, the remedy may not be so simple. Attention to the back usually relieves the discomfort, while treating the areas of focal infection may tend to prevent a recurrence of the backache.

5. *Static strain.* Postural defects are probably associated with chronic back discomfort in half the patients seeking treatment, and may be the sole cause. The back is weak structurally and anatomically, as compared with the normal back as a standard. The pain usually occurs after exertion. The patient with a faulty posture is more prone to have backache, and when it occurs it is less amenable to treatment and recurrence of discomfort is common.

A patient may complain of backache and the examination may show a normal trunk. The presence of a weak foot, a knock knee, or other static derangement of the lower or even upper extremity and its treatment may cause the back symptoms to subside. When the position of the backache is indefinite and the extremities are normal, then posture, as related to a change of occupation, a new type of automobile seat or other conditions which may add strain to the back, may be causative. Patients with congenital anomalies of the spine are subject to arthritic complications. They are, therefore, more liable to have prolonged pain and discomfort in the back associated with static strain or injury. Patients with static back disturbances suffer pain when the muscle strain is disproportionately greater than the muscle strength. The ligaments are stretched and the muscles weak.

The spine is constructed of twenty-six vertebrae. The strong bodies anteriorly and the adjacent intervertebral discs which act as buffers, are for weight bearing. The arches and processes protect the cord from injury and are for the attachments of muscles and ligaments. Numerous articulations facilitate the many spinal motions. In activity the spine is constructed to combine strength and flexibility. The anatomical consideration of the spine aids in understanding the frequent occurrence of backache as a symptom; and the complications of spinal injuries.

The conditions producing backache and their treatment are discussed in reference to the



Charts of Conditions Producing Backache, and Their Treatment

twenty-four outline drawings that are reproduced on page 584.

Picture 1. There are three physiological curves; two forward, one each in the cervical and lumbar regions and one backward in the dorsal region. The forward curves are formed chiefly by the intervertebral discs. "A" pictures the spine with, "B" without, the intervertebral discs. The fibrosis of the disc in the aged accounts for the loss of height.

In the standing position, the spine may be considered as a flagpole supported by guy ropes, represented by the muscles. The anterior support is by way of the sternomastoid muscle, through the sternum and the rectus abdominis muscle, inserting into the pelvis. Posteriorly, the longissimus dorsi starts at the base of the skull and continues through the several portions of the erector spinae group and insert into the pelvis. The analogy ceases when the number of bones composing the spine is considered; also, the many articulations, the ligaments, the muscles, and the spinal nerves emerging through the intervertebral foraminae.

Pictures 2 and 13. The spine is a complicated structure. Each spinal joint, excepting that of the bodies, has a synovial sac. Each vertebra has approximately ten synovial-lined cavities. There are one hundred and thirty-four joints between the skull and the sacrum. The articulations are so constructed that, at rest, a minimum of strain is placed on the soft tissues. The extremes of motion are checked in activity. This tends to protect the soft tissues from strain and sprain. In the weak back, especially if due to a faulty posture, locking is less efficient; stretching of the ligaments and weakening of the muscles occurs, and the patient tires or has backache. Then, due to the abnormal relation of the articulations to each other, the spine assumes an abnormal attitude. This is usually first manifested as an increase in the lumbar *lordosis* and the pelvic *obliquity*.

The free motion between the skull and the neck, and the hips and the pelvis, gives an exaggerated and erroneous idea of spinal motion. There are three primary movements of the spine,—flexion, extension, and a compound motion having the elements of lateral bending and rotation. Flexion at its maximum appears as an arc of a circle slightly flattened at the apex. Hyperextension centers at the lumbodorsal area. Lateral bending is always associated with rotation. Side or lateral bending occurs below the tenth dorsal vertebra; while rotation occurs chiefly in the cervical and dorsal spine, and also at the lumbosacral joint.

Picture 3. The examiner should know the surface anatomy of the normal trunk so as to recognize the abnormal or pathological. A median furrow is seen on inspection from the base of the skull to the sacrum. The second cervical spinous process is the first readily palpable. The seventh cervical spinous process is usually prominent. The third dorsal spinous process is on a line between the scapular spines; and the seventh is on a level with the angles of the scapulae. The interiliac line crosses the fourth lumbar spinous process; and the third sacral spine is on a line between the posterior iliac spines.

Picture 4. The patient is stripped in examining the trunk. A sheet fastened with a single safety pin at the back of the neck is a suitable drape. The only accessories needed for the examination are a backless stool, of such heighth that, when the patient is seated, the feet rest comfortably on the ground. A flat top examining table of such heighth that the patient can get on and off the table with ease (26″ high and 20″ wide); a pin; a measuring tape and a percussion hammer, complete the necessary equipment.

Picture 5. The patient is first examined in the sitting position and the drapes are displaced so as not to interfere. The manner in sitting is noted. If the patient can rest on either buttock but not on both, a painful coccyx may be the cause. A sacro-iliac lesion may be indicated if resting on one buttock is more comfortable or upward pressure on the affected side of the pelvis may be painful. (Picture 5-B.) The joint or its ligaments may be involved if pressure over the sacro-iliac joint and the ligaments toward the mid line cause pain. If the pain is greater toward the buttocks, then a gluteal or toxic myositis may be present. Tenderness to pressure may indicate an area of undue strain or the presence of an inflammatory exudate.

Picture 6. The physiological lumbar curve is diminished, but not absent in the sitting position, unless the patient slouches. If the curve is as pronounced as in the erect attitude, it is usually due to increased muscle tension or to a restriction of motion. This is either to prevent pain or it may be due to a congenital spinal abnormality.

Picture 7. The back on inspection should be studied for an abnormal attitude as a kyphosis or backward curve (A); a flat back (B); the typical "3C" curve of poor posture, backward in the dorsal region and forward in the lumbar and abdominal areas (C); and a scoliosis or a rotary lateral deviation of the spine, with an increased prominence of the ribs projecting backward on the side of deviation (D & E).

Picture 8. The carriage of the head and neck are noted. If carried too far forward, strain occurs and pain may result.

Picture 9. Flexion, when the patient is seated, should be symmetrical and occur simultaneously throughout the spine, and there should be no lateral deviation of the trunk. The dorsal and cervical spines may be seen to flex; the trunk then flex from the hips; and the lumbar spine only flex after the motion is almost completed; or the lumbar curve may persist. This indicates an effort to guard against a painful movement. Conversely, flexion may be normal and the patient may assume the erect posture by flattening the cervical, then the dorsal and finally the lumbar spine. This may occur if a lumbosacral lesion exists. The patient may push himself into the erect position by supporting his superincumbent weight with the upper extremities, if there is an inflammatory spinal lesion. This is quite commonly seen in patients with acute tuberculous or other destructive spinal lesions.

A restriction of motion in a segment of the spine may denote trouble in the area affected. Motion is usually more free above and below the fixed areas. The areas of greater motion may be the site of discomfort because of the added strain. Hyperextension centers at about the dorsolumbar area. If it occurs from the hips it suggests a stiff back, or a guarded effort to prevent a painful movement. The area of restriction may localize the site of the patient's disability. Rotation occurs in the cervical and dorsal spines and is tested with the patient's arms in the wing position, back of the head. Pain suggests trouble at the site of its occurrence. A congenital anomaly of the fifth lumbar vertebra or an elongated transverse spinous process may cause a maximum restriction of motion in the lower back.

Picture 10. Extension of the spine by lifting the head is an important test. When spinal deformity exists it aids in determining the potential progress or increase in the deformity, and the improvement which may be expected from treatment.

Picture 11. Full extension of the knees will be restricted when the pelvic joints are the seat of an acute derangement and the tension of the hamstring muscles aggravates the condition.

Those points observed with the patient seated are checked when the patient is examined in the standing position. Any lateral deviation of the spine should be compared with the attitude in the sitting position. If different, note what occurs as the patient assumes the standing position. If the curve does not change, it indicates lumbar spasm or rigidity. If the muscle tension, however, is normal, the cause is often a congenital deformity. A marked lateral deviation present only when standing suggests restricted hip motion, usually a flexion deformity (Picture 12). It may also occur in a patient with a sciatic scoliosis. A lateral deviation of the spine present in both the sitting and standing positions suggests that the hip is not involved.

Picture 13. The patient's posture is compared with that in the sitting position. The so-called "C3" attitude or the debutante slouch is unfortunately all too prevalent and the potentialities for discomfort are evident. The rôle of the abdominal wall, a guy rope of the spine, as it were, is important in its relation to visceroptosis and to backache.

The movements of the spine, with the patient standing, are next studied. Flexion of the spine from the hips should not be mistaken for free spinal flexion. A restriction of flexion in the sitting position and aggravated when the patient stands, may be caused by ten-

sion on the hamstring muscles and a stretching of the sciatic nerve. An arthritis of the hip may be present if the flexion is less marked as the patient stands.

The muscles, especially the erector spinae and those in the buttocks, should be inspected and palpated for increased tension, spasm or rigidity. A local muscle spasm may be palpated in the buttocks. It is a protective reflex, usually to prevent painful motion or to rest an irritated joint. Sensitive areas or nerve pain may be elicited by pressure. The course of the sciatic nerve should be palpated. Pain referred along its course suggests a neuritis. The pain may be referred even to the ankle and the derangement be a back disability.

Examination of the anterior aspect of the trunk begins by noting the symmetry of the chest and abdomen, or the presence of any deformities. The chest movements may indicate some intra-thoracic pathology as the cause for the backache.

The patient's ease in getting onto the table for examination in the prone position is noted. A patient with an arthritis of one hip or trouble with one sacro-iliac joint will rest his weight on the sound extremity. The patient with a painful coccyx has equal discomfort regardless of which extremity carries the weight.

Picture 14. If the hip is painful the patient lifts it onto the table with the knee extended (A). Flexing the knee by relieving the tension on the pelvi femoral muscles is more comfortable when the trouble is in the lumbar or sacro-iliac area (B). The coccyx may be palpated and motion in all joints of the lower extremities may be studied when the patient is recumbent.

A study of the pelvis shows the sacro-iliac joint to be a true joint. It is very rugged, lined with cartilage, has a synovial sac, and is bound by very strong ligaments. The sacro-iliac joint is sturdy and the examination of the joint surfaces and the wedge-shaped sacrum, or keystone in the pelvic girdle, indicates the stability of the joint to vertical strain. The joint, however, is a frequent site of torsion strains. The sacrum with its adjacent joints acts as a buffer in the transmission of every force from above or below. This, in itself, suggests the natural strength of this joint to prevent continuous injury thereto. A minor injury may cause severe symptoms even if the patient had no previous backaches. Recurrences may occur from stooping, turning in bed or sneezing. The so-called "traumatic lumbago" is usually associated with a torsion strain of the sacro-iliac joint. Recurring minor injuries may be due entirely to a faulty posture. This may cause continuous strain in the sacro-iliac joints. All tests for a sacro-iliac derangement need not be positive; but the analysis of all are essential and usually make the diagnosis conclusive.

Picture 15. This ilustrates torsion or rotation at the sacro-iliac joint. The rectus femoris is attached to the pelvis anteriorly and tension of this muscle rotates the ilium forward on the sacrum, through the sacro-iliac joint, and exerts a forward torsion strain. Tension on the biceps muscle inserted in the ischial tuberosity, or in the pelvis posteriorly, exerts a backward torsion strain. A force through these pelvi-femoral muscles is utilized in the examination to exert a strain on the sacro-iliac joints. If the symptoms can be caused or made worse by strain on the sacro-iliac joints in a given direction by the examination, then the diagnosis of a sacro-iliac derangement is tenable. Tension through the pelvi-femoral muscles is first exerted on the sacro-iliac joint of the side tested. As motion of the extremity is increased, the strain is transmitted to the sacro-iliac joint of the opposite side and then to the sacro-lumbar area and the lumbar spine in succession.

Picture 16. The straight leg raising test is commonly used in testing for sciatica. Raising the extremity causes tension on the sciatic nerve and the hamstring muscles. The biceps muscle rotates the ilium backward on the sacrum through the sacro-iliac joint. The extremity is raised (16-A) and if pain occurs and is increased by dorsiflexing the foot (16-B), an inflammation of the sciatic nerve is indicated. The tension is increased on the nerve but not on the joint. The test repeated on the well side cannot influence the discomfort of a sciatic neuritis; but, the transmission of force

through the sacrum can cause pain if the trouble is in the sacro-iliac joint.

Picture 17. Flexing both legs together places a minimum of strain, equally distributed, on the sciatic nerves and the sacro-iliac joints. The lumbar spine moves sooner than if one leg is raised. Pain, if it occurs, may suggest the location of the trouble.

Picture 18. Side flexion may be limited to the lumbar area with a minimum amount of sacro-iliac strain. It is done with the patient in the recumbent position with the knees and thighs flexed and supported on the examiner's arm. Unilateral pain may indicate trouble on the side on which it occurs. The muscle spasm which might ocur if the patient was sitting or standing is eliminated. A routine abdominal examination is always advisable and Baer's sacro-iliac point of tenderness two inches from the umbilicus, on a line with the anterior superior spine should be palpated. A consideration of an appendiceal, an adnexal and a ureteral calculus disturbance is necessary in the differential diagnosis.

Picture 19. Pain when the pelvis is compressed or distracted is usually associated with a sacro-iliac condition. The test puts a strain on the posterior and anterior sacro-iliac ligaments respectively.

Picture 20. The examination continues with the patient in the side-lying position. The hip and knee next to the table are flexed and grasped by the patient. This fixes the pelvis and prevents a transmission of strain to the lumbar spine. The uppermost knee, flexed to a right angle, is supported by the examiner and hyperextended at the hip. The strain is first transmitted to the sacro-iliac joint on the side tested, then to the other side. If the pelvis is not fixed and pain, not previously present, is elicited, it suggests that the lumbosacral or lumbar spine may be the seat of the trouble.

Picture 21. Rotary strain on the upper sacro-iliac joint may be caused by grasping the uppermost anterior superior spine with one hand and pressing the ischium forward with the other.

Picture 22. The knee is flexed to a right angle, the upper part of the thigh is pressed against the table. Raising the knee limits a forward torsion strain to the sacro-iliac joint. The strain is transmitted through the sacro-iliac joint to the lumbosacral area and the lumbar spine (22-B) if the hand pressing the thigh to the table is removed.

Picture 23. Raising both legs with the patient prone exerts a strain, usually first felt, in the lumbar spine. Raising both shoulders places a similar strain on the spinal muscles in a reverse manner. The site of discomfort may localize the disturbance.

Picture 24. Lateral flexion is practiced by carrying the extremities to either side. Localization is possible by making counter pressure with the free hand to the various parts of the spine.

The reflexes should always be tested as a part of the back examination. Patients with sciatic neuritis often have a hyperactive knee jerk, a retarded Achilles reflex, together with gluteal atrophy and flatness. These signs are not present, as a rule, in patients with sacro-iliac conditions. Low back pain early referred to both lower extremities, a disturbed plantar reflex, or an absent abdominal reflex may be an early indication of spinal cord disease.

The Lumbosacral Area. The lumbosacral joint is anatomically vulnerable and when it is compared with the sacro-iliac joint its structural weaknesses are apparent. It is often the site of trouble in patients complaining of low back pain. It may be likened to an upright girder resting upon a foundation. The analogy ceases when it is realized that the upright is composed of twenty-five bones, with many articulations and that the superincumbent weight is supported. Again the upright is not straight, but has physiological curves. The base, or pelvis, is not horizontal but has an average obliquity of fifty degrees and the fifth lumbar vertebra meets this base at an average angle of one hundred and twenty-five degrees so that even under so-called normal conditions there is an effort to prevent a forward slipping of the spine from the pelvis and an effort to maintain the upright attitude. The strain on the ligaments in this area is great.

Anything tending to increase the lumbosacral angle and the pelvic obliquity as a lordosis, a short leg, or a dislocated hip, increases

the shearing force and places a greater burden on the ligaments. The lumbosacral joint is the site of rather free motion, and stability and motion are opposed as regards strength. These facts may suggest that the cause for low back pain is often in the lumbosacral area or in the adjacent lumbar spine rather than in the naturally rugged sacro-iliac joint.

Lordosis. Patients with lordosis may complain of pain only after being in bed. The lumbar curve relaxes and there is a stretching or stress and strain at the insertion of the muscles and ligaments in the affected area. An increased lumbar curve is invariably associated with poor posture. There is no muscle spasm, and the motions of the spine are free. In the patient with an arthritic lumbar spine, the curve tends to persist and the erector spinae muscles are usually spastic. In the persistent lumbar lordosis associated with a congenital anomaly of the fifth lumbar vertebra, the muscle tension is usually normal. An increased lumbar curve is usually part of the deformity of stoop shoulders, round back, round hollow back and kyphosis.

Lordosis may be associated with a mechanical defect or improper balance. Mild structural changes may occur. Severe changes are usually associated with spinal disease. A patient with lordosis has a poor appearance when the trunk is compared with the normal. The efficiency is less, as the strain on the ligaments and stretching of the muscles entails greater effort for activity. The health of the patient may suffer, since the usually associated flat chest crowds the intrathoracic contents. A diminished inspiration subjects the patient to frequent colds and often lung diseases. The relaxed abdominal wall predisposes to ptosis and the loss of intraäbdominal tension affects the efficiency of the portal circulation with its attendant possibilities.

The Flat Back. Patients with postoperative backaches suffer from flat back strain as do those who complain of backache during an illness confining them to bed. There is a relaxation of the tissues, with a strain on the ligaments as the lumbar curve is flattened. The patient with a flat back may be as uncomfortable as the patient with a lordotic curve. Comparing the flat back with the weak or flat foot, helps in an understanding of the condition. Another cause of flat back discomfort is the strain due to a change to low-heeled shoes by an individual who has habitually worn shoes with high heels. The altered position causes a backward tilting of the sacrum. Then the undue strain at the lumbosacral junction may cause a flattening of the back and pain.

The flat back may be observed upon inspection. An absence of motion in the lower lumbar area is seen as the patient arises from the sitting position; flexes the back; and in assuming the erect position from the flexed. Although the same occurs in a patient with a lumbar arthritis, there is rarely a flattening of the lumbar spine. Further, if hyperextension of the spine is more painful than other movements, then a diagnosis of flat back may be made.

Prophylactic measures to prevent undue relaxation of the lumbar curve in bed patients and operative patients are advisable. The placing of a firm pillow under the lumbar region to protect the back during the relaxation from the anaesthetic will prevent many backaches.

A complete Roentgen-ray examination of the spine, particularly of the affected areas, is advisable. An anteroposterior and a lateral view are usually not sufficient. A three-quarter view taken with the patient turned thirty degrees to either side aids in visualizing the articular facets. A film centering at the lumbosacral angle is important. A film of the pelvis showing the hip joints and a smaller plate of the sacro-iliac joints are advisable. Stereoscopic films are always helpful.

Many patients with backache respond quickly and favorably to intensive palliative therapy. In a smaller number the improvement is very slow. A single attack may occur. Recurrence of discomfort, however, is usual. With treatment, the interval between attacks is progressively prolonged and the relief from discomfort of a recurring attack is usually rapid. The response to treatment is often as rapid in patients who have suffered for years as in those with recent backache.

No attempt has been made to do more in this

presentation of the subject of backache than to detail some of the pertinent features, especially in the examination and an interpretation of these findings; a few points in the history and a brief discussion of the etiology have been presented. The sacro-iliac, lumbo-sacral and lumbar spine areas and some of the disabilities of these parts were discussed as these constitute the usual areas affected in most patients complaining of backache.

DISCUSSION

Dr. Harry Subin commented upon the understandable and practical way in which both speakers had presented the subject. The figures presented by Dr. Rechtman were of great value in indicating how patients complaining of back pain should be examined, while Dr. Davidson demonstrated not only how inadequate the treatment was as usually administered and how varied were the resources of really curative methods. Dr. Subin again emphasized the dangers of blind reliance upon x-ray studies and the vital importance of basing therapeutic measures upon the results of careful physical examination.

Dr. S. L. Salasin commented upon the value of these papers to the general practitioner and discussed the occurrence of backache in relation to foot strain and in prostatic disease.

Dr. C. H. deT. Shivers emphasized the importance of prostatic examination in every case of backache and the value of the infra red rays and the static wave currents in the treatment of this condition was discussed by Dr. William Martin.

Dr. W. C. Wescott recalled that the negative value of the negative x-ray film in the study of backache had long been recognized and was first emphasized by Goldthwaite. The x-ray cannot be expected to show edema, hemorrhage, or other acute inflammatory processes which may be responsible for the pain but can show only the amount of motion possible in the joint.

Abnormalities must be carefully interpreted in theri relation to trauma as approximately 20 per cent of patients present congenital abnormalities, the presence of which is only recognized when an accident has led to x-ray examination.

ON MISTAKING OTHER DISEASES FOR CORONARY THROMBOSIS

By James B. Herrick, M.D., Chicago, Ill.

Read before the General Session of The Medical Society of New Jersey at its 169th Annual Meeting on May 1, 1935, in Atlantic City

In the last two decades acute obstruction of the coronary artery has emerged from the obscurity of a pathologic curiosity into the clear light of a well-known clinical condition. A *disease* one may call it, or if one is willing to expose oneself to criticism from the purists, a *clinical entity.*

CALLING CORONARY OCCLUSION SOMETHING ELSE

Many writers have directed attention to the ease with which this condition may be mistaken for something else,—acute dilatation of the heart, acute heart failure, ptomaine poisoning, acute indigestion, cerebral hemorrhage, or cerebral thrombosis. Special warnings have been uttered as to the danger of regarding it as perforating peptic ulcer, pancreatitis, disease of the gall-bladder, or other acute subdiaphragmatic emergency that is tersely and vividly, though not grammatically, called "acute abdomen". The revelations of the autopsy, of the misdirected surgical operation, or of the subsequent clinical course have only too often shown that there was need for such warnings. In fact, the need still exists and especially since the conception of the clinical manifestations has been broadened so as to include many deviations from the picture originally drawn which is often referred to as the typical case.

It is now well-known that there are cases in which subjective and objective symptoms are minimal, others in which the symptoms are out of the ordinary. To express it in another way, there may be quantitative and qualitative variations from the hypothetical standard so that we hear much today of mild and atypical cases—Some with symptoms so slight or so unusual as to throw the doctor off his guard and lead him to interpret the upset as purely phobic or neurotic in character; cases in which pain may be absent,

perhaps replaced by dyspnea; cases with strange variations in blood pressure, in rate, rhythm and quality of the heart's beat; an astonishingly quick recovery from an attack with unusually severe onset, or an equally mystifying delay with faltering or incomplete come-back after a seemingly mild seizure.

The electrocardiogram, too, may be anything but clarifying. The necessity, therefore, for a critical study of all suspected cases is as great as ever, even greater. One recent writer, with sarcasm that seems a little too caustic, thus refers to the ease with which physicians may overlook the condition entirely:—"Too many patients are still given alkaline mixtures for dyspepsia, or patted on the back, and advised to take vigorous exercise for their so-called neuritis, or, less often, subjected to a laparotomy as cases of ruptured peptic ulcer."

So, one major diagnostic error is to regard coronary occlusion as something else, than what it is.

CALLING OTHER CONDITIONS CORONARY OCCLUSION

In the present paper I wish to call attention to another major error which is the *converse* of this, viz., that of calling some other condition acute coronary occlusion. This mistake is not infrequently made. This is largely due to the fact that there has developed a tendency—one might facetiously refer to it as a fashion or fad—to regard too readily any pain in the front of the chest, any increase in the heart's rate or alteration of rhythm, as indicative of an existent disease of the heart or of a threatened "heart attack". The layman, fed up by front page statistics, by radio talks and magazine articles as to the increase in deaths from heart disease, has become not only heart conscious but heart panicky. And the doctor himself has unwittingly been infected by the epidemic of heart consciousness. Anxious to guard his patient against the evil consequence of overlooking this serious condition, without due consideration of other possible causes for the symptoms, he diagnoses coronary thrombosis. Fortunately, the unnecessary rest in bed that he commonly prescribes is generally harmless; it may be beneficial. Unfortunately, however, it sometimes robs the patient of the benefits of timely surgical treatment or of a more suitable medical management. Unfortunately, too, it may aggravate an already existing psychoneurosis. We all know how deplorable is the condition of the one who has a well-fixed fear concerning his heart.

Before taking up the diseases that are at times wrongly regarded as coronary occlusion, let me make three statements:

1. I am confining my remarks almost exclusively to the franker and acuter manifestations of occlusion. I am not, except incidentally, considering that large and important group in which there is slow often silent, obstruction of the coronary arteries especially in the smaller branches that leads to *myomalacia cordis* and *disseminated fibrosis,* the *fibrous myocarditis* of our younger days, now more aptly called *chronic degenerative myocarditis.* While this might not improperly be included, the commoner, gradually ingravescent symptoms like dyspnea, cyanosis, and edema are not those that are apt to lead to the error I am stressing today. This form is, therefore omitted.

That mistakes of this sort are made need excite no surprise. To err in this manner is in accord with the history of clinical medicine.

2. Following the uncovering of some hitherto overlooked disease, or the announcement of some new method of laboratory or instrumental diagnosis, physicians have often been carried away by their enthusiasm so that they see the disease where it does not exist. Many a disease has its day much as does the best seller in the book market. When it became known that inflammation of the appendix was the cause of a large proportion of cases of perityphlitis and peritonitis, physicians, in order not to commit the error of overlooking appendicitis, went to the opposite extreme and regarded as appendicitis other conditions with somewhat similar symptoms—salpingitis, extra-uterine pregnancy, twisted pedicles, herniae, gall stones, ureteral calculi, spastic bowel, simple neuroses. The same was true of tu-

berculosis of the lung. Appalled by the revelations of the intensive study of tuberculosis, especially by x-rays and autopsies, physicians, laudably desirous of giving their patients the benefit of rest, isolation and fresh air, too often jumped to a wrong diagnosis of tuberculosis. Even specialists in this disease in private or sanitarium or government practice have frequently erred. In some series an error of 10 to 30 per cent has been admitted. Pulmonary infections by germs other than the tubercle bacillus, bronchitis, bronchiectasis, asthmatic conditions, neoplasms of the lung, syphilis, etc., have been wrongly called tuberculosis. Incompetence, hurried examinations, misreading of x-ray plates, errors in physical diagnosis or in laboratory technic account for some of these blunders. Many errors, however, have been due to the fact that these other conditions have been overlooked because not thought of and, therefore, not sought for. So, this feature of the diagnosis of coronary occlusion is not novel.

3. There is no intention of conveying the impression that the differential diagnosis of coronary occlusion is always easy. It may be, or it may be decidedly difficult, so perplexing, in fact, that at times with most careful study, with help from laboratory, instruments of precision, and consulting specialists, one is left in doubt. Merely to remember the possibility of the existence of other diseases than a cororary thrombosis may put one on the track that leads to the solution of the diagnostic problem.

CONDITIONS WRONGLY DIAGNOSED

I have personally seen 28 different conditions wrongly regarded as acute coronary occlusion. My paper is little more than the reading of the list of these diseases with brief comments on a few only of the more puzzling or more important conditions. How many of these mistakes were mine and how many of others with whom I saw the patients I am not telling. Whether this reserve on my part is from modesty or embarrassment you may not know.

ANGINA PECTORIS

It was through the doorway of *angina pectoris,* which almost by definition implies pain, that acute coronary occlusion entered into the household of clinical diseases. In fact, some still make coronary thrombosis a subhead under angina. It is not to be wondered at, therefore, that angina pectoris closely related pathologically, often combined with acute occlusion, and having many similar symptoms, is frequently misinterpreted. It is well, however, from the standpoint of prognosis and treatment to distinguish where possible between the pain of effort which disappears after quiet or the use of nitrites, and which speaks for a temporary relative ischemia of cardiac muscle, and the more enduring pain of permanent obstruction which comes on often without provocative effort which is attended by the shock, dyspnea, arrhythmia, fever, leukocytosis, electrocardiographic changes all now so well-known.

ARRHYTHMIAS

Cardiac arrhythmias may, especially in the neurotic, simulate acute coronary obstruction. Extrasystoles particularly if in paroxysms, as well as flutter, auricular fibrillation and paroxysmal tachycardia may be attended by some pain. The anxious sufferer, fearing death, has a disturbed respiration, the skin may be of changed color and bathed in sweat. The pulse disturbance may be alarming to patient and doctor. A careful study showing absence of the more striking positive signs of the acutely damaged heart will usually enable one to assess these symptoms properly.

NEUROSIS

Aggravated cases of cardiac neurosis, neurocirculatory asthenia, are sometimes perplexing, especially if met with in a physician, nurse, or other heart conscious individual. In some, time for repeated observations as to temperature, leukocytosis, blood pressure, serial electrocardiograms, is necessary before one may positively exclude coronary obstruction.

MALINGERING

Real or suspected malingering may be most puzzling. A physician, who a few weeks before had taken out a health insurance policy, came to me believing he had had an acute obstruction. His story seemed almost too classic to be true. Physical examination revealed no organic change. The electrocardiogram was not helpful. Later he described a slight subjective cardiac uneasiness suggestive of angina. Again examination failed to show objective signs. Believing in his honesty and convinced he was not unduly imaginative, I could interpret the history in only one way, that he had had a coronary attack. The insurance company, though wishing to do the square thing by him, was more than suspicious, watched him, had their doctors examine him, and paid the monthly disability claim with reluctance. About four months later by suddenly dying a typical coronary death, he cleared up the situation as to diagnosis and removed the cloud on his title as an upright, honorable man.

PERICARDITIS

It is well known that pericarditis from other causes than myocardial infarction—rheumatism, tuberculosis, or other infections—may resemble very closely acute coronary obstruction. Pain of onset may be rather abrupt, may be substernal and epigastric, may go to the arms. There is disturbance of heart rate, perhaps arrhythmia. Blood pressure may be altered. Dyspnea and cough are common. Fever and leukocytosis are present. The friction sound may be regarded as revealing a pericarditis secondary to infarction. Still more confusing, when there is much effusion, the electrocardiogram may resemble that of acute obstruction perhaps because there is cardiac dysfunction and altered conduction the result of myocardial inefficiency due to associated inflammation or to pressure of the fluid. Only most careful analysis and watchful waiting will in some cases decide as to diagnosis.

ANEURYSM

The pain and distressed breathing together with changes in cardiac action due to *syphilitic aortis,* with or without definite aneurysm, may be wrongly interpreted. So may the sudden severe pain of a dissecting aneurysm—which is usually in a non-syphilitic individual—with its shock and frequently altered heart rate and rhythm. In the cases of dissecting aneurysm that I have seen the location of the pain in the back of the chest with x-ray findings have been especially helpful in diagnosis.

Rupture of the aorta into the pericardial sac, a not uncommon termination of dissecting aneurysm, may resemble very strikingly acute coronary thrombosis. In one instance my pride at having correctly diagnosed the dissecting aneurysm several weeks before took a heavy fall through the error of mistaking the terminal intrapericardial rupture for thrombosis. More careful physical examination and consideration of details might have spared me this error.

LUNG CONDITIONS

Several times I have seen pleurisy or pneumonia suspiciously viewed as coronary obstruction. Also carcinoma of the bronchus or lung has created doubt, as has massive collapse of the lung. This collapse was once due to carcinoma. In some cases it has followed operations.

Twice acute *pneumothorax* was the cause of the error. In one case the pneumothorax was partial, adhesions restricting the cavity to the upper left chest. The other case was that of a physician who, as he was dressing in the morning, was seized with a sudden pain in the left chest. He felt weak, was nauseated, noticed that his pulse was rapid and rather small; he breathed with difficulty. He feared a coronary accident as did I until, on physical examination, I found the heart displaced to the right, noted the altered signs over the lung on percussion and auscultation, and by x-ray confirmed the diagnosis of ruptured lung. It is of interest to add that in neither of these cases could proof be established that there was tuberculosis of the lung. In neither case did fluid appear. The ambulatory patient with partial pneumothorax who had come to me a few days after his accident

recovered without rest in bed. The other patient, the physician, had an anxious time of it with complete bed rest for many days, but eventually made a complete recovery.

PULMONARY EMBOLISM

Pulmonary embolism deserves a more extended consideration than can here be given. Surgeons are often robbed of the results of operation, especially abdominal operation, by the pulmonary embolus that originates in the thrombosed veins—about the prostate, uterus, gall-bladder, or appendix. From the medical wards where patients are confined because of broken down hearts or other debilitating disease comes the same story of thrombosis perhaps in the femoral or popliteal vessels, with sudden embolic death.

We need not discuss here the still unsettled question as to the causes of thrombosis or as to its apparently increased occurrence. The point to emphasize is that an embolus in the lung, unless it be quite small, may cause sudden symptoms that mimic in marvelous manner those so often seen in the fulminant type of acute coronary obstruction. The pain may be severe in the sternal or lateral region of the chest or in the epigastrium; it may go to the arms. Dyspnea is pronounced. There is shock, an ashy countenance, a drop in blood pressure. The pulse generally becomes rapid and small, and may be irregular. The temperature may rise and the leukocytes are increased. The electrocardiogram may resemble that of a coronary attack. Death may be a matter of a few seconds only, or of hours or days. Yet recovery is common, even in seemingly desperate cases. No wonder one must hesitate as to diagnosis. If a pleural friction sound appears, with an area of dullness and with other signs of consolidation; if the x-ray shows such an area; if the sputum becomes bloody, one may feel surer that there is a pulmonary lesion, such as an embolism, an infarction, a pneumonia, or a massive collapse. The history of an operation a few days before or the finding of signs of a thrombosis in the superficial or deeper veins of the leg is ground for suspicion.

The problem may however, be rendered still more intricate when one reflects that a pulmonary embolus with infarction may be the result of a coronary obstruction. An intracardiac thrombus that forms over the damaged myocardium may be—as when the septum is involved—in the right as well as left ventricle. Embolus from this source goes to the lung.

HERPES ZOSTER

Herpes zoster is a prolific source of diagnostic error, at least until the skin lesion is in evidence or is brought into the evidence by being recognized. Twice I have seen herpes called acute coronary thrombosis.

ARTHRITIS

Mention must be made of the ease and frequency with which arthritis may lead us astray. Inflammatory changes in the costochondral articulation, the shoulder joints including the neighboring bursae, have more than once been the cause of misinterpreted distress.

But it is *spondylitis* of the cervical and upper dorsal spine that oftenest confuses. While the confusion is more likely to concern the diagnosis of angina pectoris than coronary thrombosis, the question may arise when the arthritic pain has been especially sharp and when it has persisted. Examination of the spinal column for tenderness or for pain on motion; x-ray studies, therapeutic use of heat, etc., may clear up the case. Helpful hints are that such pains less often follow walking than they do shifts in the position of the body, such as turning or twisting. The pains may last longer than is consistent with angina pectoris, though this prolongation of pain may be the fact that rouses suspicion of coronary obstruction. Weather may influence their occurrence. They are not attended by the cardiac disturbances of acute coronary obstruction.

A great difficulty arises when a patient has both angina and arthritis.

ABDOMINAL SYMPTOMS

Coronary thrombosis, as has been mentioned, may cause abdominal symptoms that may lead to the suspicion of an acute abdom-

inal accident. Conversely abdominal conditions may cause symptoms in the chest that may make one suspect a cardiac accident. The pains of gall stones, ulcer, or carcinoma of the stomach or duodenum may be misleading by being referred to the chest. In general such conditions, if thought of, are recognized without much difficulty.

An acute gastritis—one must still cling to the belief that there is such a condition—due, perhaps, to dietetic error—may by pain, vomiting, weakness, disturbed pulse, slight fever, etc., be a source of error.

A colleague once set me right by convincing me that a chest pain in a neurotic patient was due neither to angina nor to coronary obstruction. It was the pain of a spastic and irritable bowel. I got even with him later when I showed him that the supposed acute coronary occlusion in one of his patients—pain, rapid pulse, drop in blood pressure, slight fever, grayish countenance and signs of shock—was due to hemorrhage from a duodenal ulcer threatening perforation. The pronounced anemia, the tarry stools found unevacuated in the rectum together with the better interpretation of the past history and of the x-ray film gave the clew.

The problem presented by a puzzling case of eventration of the diaphragm was worked out by a careful physical examination of the chest, and by x-ray.

Not a few cases of hernia of the diaphragm are reported in which a coronary accident has been suspected. I have seen, at least have recognized, only one such error. A doctor who said he had had a "growling gall-bladder" with occasional colicky attacks, came to me much alarmed by what he and another colleague felt sure was an angina with a coronary occlusion. The case was by no means clear. I satisfied myself by the dye test that there was no evidence of a pathologic gall-bladder. On fluoroscoping his stomach there was found a diaphragmatic hernia that would hold perhaps two ounces. The doctor, however, was not convinced. Perhaps he was alarmed at my suggestion of a conference with a surgeon. I have not seen him since, though I believe he is living.

Once I saw a tabetic with gastric crisis in whom there was a question as to a coronary accident. There was no proof that such had occurred.

DIABETES

Coronary thrombi are not unusual in diabetics who are especially prone to have arteriosclerosis. One has to be wary, however, in diagnosing an acute obstruction in a diabetic who with chest pain, dyspnea, shows even quite suddenly symptoms of collapse with faltering pulse and drop in blood pressure. Oncoming coma may quite closely simulate a coronary attack. On the other hand one must not too hastily diagnose chronic unrecognized diabetes in a patient who has an acute thrombosis, for sugar in the urine is not at all unusual in patients suffering from this accident.

CONCLUDING COMMENT

The conclusion of this paper might be boiled down to the statement that it is easy to mistake other diseases for coronary thrombosis. This is a statement that none would have denied before hearing the paper. Then why was it advisable to write or to read it?

Is it not true that some of our most embarrassing and costly errors are due to the fact that, for the moment, we forget things that we know full well? That in looking for the unusual we overlook the obvious? That merely to think of the other disease, simple though it may be, is often to avoid the error?

The object of this paper, then, has been not to present something new, but to repeat something of value that is old—lest we forget.

CORONARY DISEASE AND CORONARY THROMBOSIS IN YOUTH

AN ANALYSIS OF 4 CASES UNDER THE AGE OF THIRTY YEARS, 21 CASES UNDER THE AGE OF FORTY YEARS, AND 138 CASES UNDER THE AGE OF FIFTY YEARS

By Paul D. White, M.D., Boston, Mass.

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A talented physician of Hebrew ancestry forty-two years old consulted me two years ago because he had been troubled for nearly a year by a disagreeable sensation of substernal oppression on effort like climbing a hill, especially after meals. The discomfort would subside in a few minutes on resting; it never came when he was quiet. During the winter it had increased somewhat. He was more concerned that he would be rejected for life insurance because of it than that it might bode ill for him otherwise. He was healthy in other respects, happy at home and in his work, but under considerable nervous strain in recent years. He was well built but exercised little. He had smoked heavily for years, and was quite certain that the more he smoked the more substernal oppression he was inclined to have.

Physical examination, electrocardiogram, and fluoroscopy showed nothing amiss, but he was advised to reduce or omit his tobacco, to avoid much of any physical effort for a while, and to avoid overeating and gaining weight.

On reducing his tobacco and with the onset of warm weather he improved a good deal, and only occasionally had any substernal oppression. Recently, at the age of forty-four years, he dropped dead after dancing, when apparently in excellent health and two and one-half years after the onset of his angina pectoris which he himself had attributed largely to his tobacco.

Postmortem examination showed no abnormalities except marked narrowing of the lumen of the descending branch of the left coronary artery by atheroma with fibrosis, the so-called *youthful* type of coronary atherosclerosis such as Leary[1] and others have described in detail of late. There was no actual occlusion or myocardial infarction. The heart was of normal size. There was no aortic lues.

This man's father had died suddenly at the age of fifty years.

Ten years ago an Irish-American, the medical director of schools in a city near Boston, came for examination because he was much worried about attacks of substernal oppression on effort that began three years before when he was thirty-nine years old, and about a severe attack of so-called "acute indigestion" that had occurred three weeks before the examination. The oppression would always subside in a few minutes on resting. He was an extremely nervous, slight man who had had asthma for many years. He had had no important infections, and his Wassermann reaction was negative. He had smoked heavily for years, and had used much coffee but little alcohol. He exercised little. His family history was good except that one brother and one sister had pulmonary tuberculosis.

Physical examination was entirely normal. The electrocardiogram, however, showed inversion of the T waves in leads 1 and 2, and ventricular premature beats.

Rest and omission of tobacco were advised, and he returned seven months later feeling better but still troubled occasionally by substernal oppression on effort, relieved quickly by nitroglycerine. Physical examination again showed no abnormalities, but the T waves in lead 2 of the electrocardiogram were still inverted.

Two months later he dropped dead when on a visit to another city.

A sculptor of English stock aged thirty-seven years came for opinion and advice in July, 1930, with the story that six months previously he had been taken suddenly ill with very severe substernal oppression radiating to both arms and not wholly subsiding for weeks. He said that he had remained in bed only two days and then, although feeling very miserable, had resumed work. Finally, he had become so weak and short of breath that he had had to give up work.

Past history revealed considerable tonsillitis and scarlet fever in 1911, facial paralysis for a few months following a skating accident in 1912, and a crushing injury at camp during the war in 1918. He had smoked very heavily in the past and had used much coffee but little alcohol. He had exercised much. His family history was unimportant except that his father is said to have died of nephritis at sixty-seven years of age.

Physical examination showed a tall, thin man, very nervous and slightly dyspneic. He had an arcus senilis in each eye. The cervical veins were moderately engorged and pulsating. The heart was much enlarged with poor sounds, apical protodiastolic gallop rhythm, and accentuated pulmonary second sound. The pulse was small at a rate of 84 and the blood pressure was 110 mm. mercury systolic and 85 diastolic. The lungs were clear. The liver showed some enlargement and tenderness and there was soft edema over both ankles. An electrocardiogram revealed partial auriculoventricular block, intraventricular block, and low voltage.

After digitalization and rest he was markedly improved, and after a year he was able to resume light work. On May 12, 1933, three and one-half years after his attack of very severe myocardial infarction, he seemed in excellent health with no evidence of congestive failure, and with his heart

only slightly enlarged. Low voltage persisted in the electrocardiogram, but the auriculo-ventricular block had disappeared.

On November 25, 1934, five years after his first acute illness, one week after the onset of angina pectoris decubitus and four days after an evident second attack of coronary thrombosis, he died suddenly. Just prior to his final illness he had become careless and had been working very hard again.

A medical student of Jewish origin, twenty-six years old, never ill before except for acute appendicitis with operation in 1921, was taken sick on November 21st, 1926, with fever, nausea, and headache the morning after a night of prolonged study and the smoking of five cigars. He improved rapidly, slept well that next night, and walked more than a mile to the hospital (in Montreal) for a clinical exercise in the morning. While at the clinic he was taken suddenly with severe nausea, was put to bed in the hospital, and shortly thereafter was seized with a very severe precordial oppression radiating down his left arm. Amyl nitrite gave no relief and five hypodermic injections of morphia were necessary. The pain lasted sixteen hours. The blood pressure measured 105 mm. mercury systolic and 88 mm. diastolic the next day and there was slight fever (to 101° F.) which lasted five days. The leukocyte count was 11,000 to 12,000. Several electrocardiograms were typical of acute myocardial infarction.

After two weeks in the hospital in Montreal he returned home to convalesce and for the first week at home he felt well. Then heart failure began with pulmonary edema, and after several weeks he was admitted quite ill on January 6th, 1927, to the Massachusetts General Hospital, one and one-half months after the onset of his acute illness. The heart was found to be moderately enlarged, the rhythm was regular, and the rate was 100; there were no murmurs. The pulmonary second sound was accentuated. The blood pressure was 102 systolic and 70 diastolic. There was no edema of the legs. An electrocardiogram showed deep late inversion of the T waves in lead 1, with rather high origin and rather wide QRS waves. He improved rapidly and returned to the medical school, graduating that following June. In August, 1927, he felt well and since then he has been actively practicing. It is now over eight years since his coronary occlusion. He is thirty-four years old.

These individuals and others like them present a challenge to us all. We cannot say with a shrug of the shoulders, as we are wont to do in the case of patients with angina pectoris or coronary thrombosis in the seventh and eighth decades, that the coronary disease is but a natural result of old age and steps in to prevent a long senescent invalidism. This young group and in fact all patients with coronary disease under the age of sixty years, if we may set some arbitrary mark, neutralize somewhat our inclination to feel pleased that heart disease as an ending of life has been increasing largely because the reduction of other diseases, especially infections, has permitted the survival of many persons now to ages when heart disease may begin its ravages.

It is important therefore in the first place to determine how frequently serious coronary disease attacks persons in youth and in early middle age, and in the second place to try to learn from a study of such patients what the characteristics of such early coronary disease may be and whether or not we may find some clues to aid us in its prevention. It was with these thoughts in mind that Dr. Glendy and I began our clinical investigations a year and a half ago, and it is of the results of the study to date, at about the half-way mark, that I shall speak today.

DEFINITION OF CORONARY DISEASE

By coronary disease I mean disease of the coronary arteries themselves and not the symptom, angina pectoris, which may be associated with several different conditions causing coronary insufficiency. I am not including in the present report, except to mention them, cases of angina pectoris due to narrowing of the coronary mouths from luetic aortitis, and cases associated with rheumatic aortic regurgitation of high degree in young people, or those accompanying thyrotoxicosis, or severe anemia or congenital defects (as in one striking instance that we have seen of death in infancy due to the fact that the left coronary artery arose from the pulmonary artery). Although coronary disease may be present in some of such patients, the condition is a complicated one. Therefore, it is best to stick to uncomplicated cases so far as it is possible to do so.

Atherosclerosis with a variable amount of fibrosis is the main problem in coronary disease in youth and middle age. Evident infectious lesions of importance are rare, and embolism still rarer.

Coronary disease, as defined above, is to be recognized clinically by the occurrence of *coronary thrombosis*, the diagnosis of which is usually easy, by the occurrence of *angina pectoris* without any evidence of lues, valvular

disease, thyrotoxicosis, severe anemia, or congenital defects; and by the finding of characteristic *electrocardiographic changes,* which demand careful analysis particularly in young individuals.

It is important to distinguish, as suggested already, between coronary disease as such, and the symptom of coronary insufficiency, namely angina pectoris. They may run parallel in degree, but often they differ widely. There may be much coronary disease or even coronary insufficiency without angina pectoris; and there may be a high degree of angina pectoris, and dangerous too, without much coronary disease. Here enters a large *nervous* element, the so-called individual sensitiveness and nervous strain. Four years ago last December I spoke on the topic "An Evil Consequence of Strenuous Living—Angina Pectoris",[2] and although the intervening years have altered very little my point of view concerning angina pectoris, the problem of coronary disease underlying angina pectoris, and the problem of coronary thrombosis are another matter and may indeed not be directly related to strenuous living or the ordinary or extraordinary wear and tear of life.

Finally, before leaving the matter of definition, it is extremely important to insist that thoracic and arm pains and aches associated with neurocirculatory asthenia be carefully distinguished from angina pectoris as Heberden[3] described it and as we now consider it. It is astonishingly common, however, even now to encounter loose diagnoses of "secondary" or "pseudo-angina pectoris" in nervous persons with no coronary disease; even Mackenzie[4] included a number of such patients among his case reports of angina pectoris. It is easy to weed them out by the histories recorded.

THE PRESENT STUDY

In the present study we have collected *first,* the data on cases of coronary thrombosis and of uncomplicated angina pectoris occurring under the age of 40 years, that we have ourselves examined in the past fifteen years, for comparison with our total series of cases of coronary thrombosis and of angina pectoris of all ages; and *second,* certain features about these same cases and others under the age of 50, for comparison with similar features concerning a group of very old persons, ranging in age from 80 to 105 and for the most part in good health. In this latter study we found that we could use also the data that Pearl[5] has been collecting somewhat in the same way concerning nonagenarians and centenarians. Our own old age group study will incidentally be of interest in comparison with Pearl's.

FREQUENCY OF CORONARY DISEASE

Atherosclerotic lesions of the coronary arteries are very common in middle-aged and old individuals, and not uncommon even in the young. Infrequently they have been noted in the first decade. Notably Wolkoff (1929)[6] and Ehrich, de la Chapelle, and Cohn (1931)[7] have demonstrated the increasing frequency of fat accumulations in the coronary walls with increasing years, the anterior descending branch of the left coronary artery being the first vessel affected in the early decades, while the right coronary artery does not show any regular deposits until the fourth decade, and the posterior descending vessel until the seventh. Leary[1] believes that the fibrosis that develops in and about the atheromatous areas is a reaction of youth, while the calcification that comes eventually in these same areas is a gravestone indicating the end result and the death of the tissue. Long before calcification occurs the earlier process of atherosclerosis in the form of atheroma and fibrosis may be a serious condition leading to sudden death or thrombosis.

Like many other pathological processes in the body coronary disease is much more common in slight and unimportant degrees, to be diagnosed only at the autopsy table, than in an extent sufficient to cause symptoms or clinical signs, or to cripple or endanger life.

Series of Hospital Cases: A few weeks ago I reviewed the portmortem reports of 100 consecutive individuals under the age of 40 years autopsied at the Massachusetts General Hospital in recent years, and in whom the coronary arteries had been carefully examined grossly. In 88 cases no lesions were observed;

in 6 there was very slight atheroma at ages ranging from 18 to 38 years; in 3 there was slight atheroma at 26, 32, and 35 respectively; in one (a woman 32 years old with mitral stenosis) the atheroma was moderate, in one case (an obese man of 32) it was considerable, and only in the remaining case, a man of 37 years, was it marked. In the last case death occurred suddenly and autopsy showed a complete old fibrous occlusion of the descending branch of the left coronary artery without any sign of a myocardial infarct. Over a period of several years there was only one other patient under the age of 40 who came to autopsy and showed coronary occlusion on an atherosclerotic basis; that case showed a myocardial infarct. Meanwhile four other cases showed complete or nearly complete occlusion of coronary mouths by luetic aortitis—all males, two of whom were under 30. One other patient showed coronary mouth occlusion due to pressure of a vegetation on the aortic valve in subacute bacterial endocarditis.

Series of Private Cases: Turning now to our series of private patients during the past fifteen years we find clinical evidence of important degrees of coronary disease in youth more commonly than among the autopsied hospital patients. This is true for several reasons, most important of which are that the manifestations of coronary disease are more likely to be treated in the doctor's office or outpatient clinic, or in the case of coronary thrombosis at home, than in hospital wards, and that sudden death which often terminates these cases usually occurs during the routine of more or less active life and not inside a hospital. The medical examiner or coroner more often meets these cases than does the hospital pathologist. In fact Timothy Leary of Suffolk County in Massachusetts has given us much help in showing us his coronary artery findings in young individuals who have been killed or who have died suddenly.

Among my private patients with cardiovascular symptoms or signs there have been just 1201 who have had unquestioned coronary occlusion, angina pectoris, or both. Of the 1201, 976 had angina pectoris, and 418 had coronary occlusion; 193 were duplicates, having both angina pectoris and coronary occlusion.

Among the 418 patients with coronary occlusion there were 14 under the age of 40, which make 3 per cent. Among the 976 patients with angina pectoris there were 21 cases under the age of 40, or 2 per cent; seven of these 21 cases we ruled out for further study because they were complicated by luetic aortitis (2 cases), or marked aortic regurgitation of rheumatic origin (5 cases). The problem of luetic aortitis with angina pectoris in youth is not a part of our present study; nor should there be included, I believe, the group of young cases with rheumatic aortic regurgitation and angina pectoris, which Seeley Mudd and I [8] discussed a few years ago with the presentation of eight cases, and which Sir Thomas Lewis[9] has discussed since then.

Thus 14 of the 976 cases with angina pectoris under the age of 40 years may be considered to be on a basis primarily of coronary disease or atherosclerosis. Seven of the young cases had both coronary occlusion and angina pectoris. Hence, out of the total of 1201 coronary cases in the entire series there were 21 under the age of 40 years (one and two-thirds per cent).

Series in Medical Literature: In other groups of cases of coronary disease reported in the literature one finds occasional young cases. For example, Conner and Holt[10] reported that 8 per cent of their series of 287 cases of coronary thrombosis occurred before the age of 40, and one per cent before 30. Levine's[11] series of 145 cases of coronary thrombosis contained three between the ages of 30 and 40; one of those was syphilitic. In Parkinson and Bedford's[12] autopsied series of 83 cases of coronary occlusion there were two patients under the age of 30, both embolic and hence not belonging here; there were three others with coronary thrombosis between the ages of 30 and 40. In a clinical series of 100 cases of coronary thrombosis of these same authors there were two cases between 30 and 40 years old. Barnes and Ball[13] reported two cases under the age of 40 years out of 49 with gross myocardial infarction examined postmortem. Seven of the 62 proved cases of cor-

onary thrombosis reported by Meakins and Eakin[14] were under 40 years old. Four of the 15 cases of myocardial infarction of Kerr and his associates[15] were under 40, but two of these were consequent to subacute bacterial endocarditis; the other two were men aged 32 and 38 respectively. Five of Christian's[16] 71 cases were under 40 years old, the youngest 31. One of 100 autopsied cases showing myocardial infarction or gross fibrosis reported by Lisa and Ring[17] was 28 years old. Smith and Bartels[18] cited two persons under the age of 40 years with coronary thrombosis and myocardial infarction proved postmortem; one was a man aged 35 and the other a man aged 36. Clark[19] reported the case of an aviator 30 years old who died suddenly and whose autopsy showed cardiac infarction without syphilis. One of Coelho's[20] 28 cases was a man 34 years old. The youngest case of coronary thrombosis due to atherosclerosis with typical clinical course to death and autopsy that I have found in the literature was a lad 18 years old reported ten years ago by Jamison and Hauser.[21] There may be others that I have not noticed. The cases of the two infants on record[22 23] with cardiac infarction, one aged three and one-half months with sepsis and rupture of the heart, and the other aged 19 months with septicemia and embolism, are not to be ascribed to coronary disease as such. The same is true of Hammer's[24] famous case diagnosed by him ante mortem and reported in 1878, a young man of 34 years with bacterial endocarditis and occlusion of the mouth of the right coronary artery by an aortic valve vegetation, and a pulse rate which dropped to 8 per minute before death. West[25] reported a similar case in 1931, a 31-year-old woman who died suddenly while playing tennis as the result of coronary embolism caused by an aortic vegetation,—she had subacute bacterial endocarditis. The youngest woman that I have read of with coronary sclerosis and occlusion and myocardial degeneration was reported by Rathe;[26] she was 33 years old. Historically it is of interest that in Marie's[27] famous thesis of 1897 the first of his series of 37 cases of myocardial infarction was a woman 38 years old; she showed a thrombosis of the left coronary artery with infarction of the anterior surface of the left ventricle.

Before leaving this matter of the frequency of coronary disease in youth I would refer to the case reports on angina pectoris by Gallavardin[28] and by Mackenzie.[4] Gallavardin reported that in 38 cases out of 476 the trouble began before the age of 40 years; his youngest case, a woman of 22, and several others were syphilitic, and therefore the figure of 8 per cent is quite definitely above that which includes only the atherosclerotic cases. Mackenzie in the appendix of his book on angina pectoris includes among 160 cases twenty under the age of 40 years; but of these 8 had neurocirculatory asthenia as the cause of the chest pains and aches; 6 had rheumatic aortic regurgitation; and 2 were luetic; leaving only 4 in whom coronary disease as such might be blamed for the angina pectoris.

DATA OF OUR OWN 14 CASES OF CORONARY THROMBOSIS UNDER THE AGE OF 40 YEARS

All were males in contrast to 83½ per cent of males of a series of 200 cases of coronary thrombosis of all ages previously analyzed by Dr. Bland and myself.[29] There were four under the age of 30 and these were of Jewish ancestry; they were 22, 23, 26, and 26 years old respectively. The other ten were aged 31, 31, 35, 37, 37, 38, 38, 39, 39 and 39; four were of English stock, three Irish, one French Canadian, one Spanish, and one Turkish. Eight of the fourteen were in business, one was a dentist, one a medical student, one a sculptor, one a sheriff, one a mechanic, and one a baker. In build seven were stocky, six average, and one tall and thin; none were very fat or small. Only three were of nervous temperament; five were the reverse. All used tobacco, most of them (10) to excess—that is, more than 20 cigarettes a day. The majority (10) took little or no alcohol; two drank much. The amount of exercise varied from much to none. Bowel habits were normal in eleven.

The past history showed very few infections; eight had had none at all except the mildest childhood diseases (measles, chicken pox, or whooping cough). Two had had gon-

orrhea, one scarlet fever, one rheumatic fever, and two tonsillitis.

The family history was good or excellent in six of the fourteen cases; in two cases the father had died of heart trouble under the age of 60 years; in two a brother had died of heart trouble; and in one the mother had died with heart disease.

Hypertension was present in none, in contrast to 25 per cent of the series of 200 cases of all ages. No case had diabetes. The heart size varied from normal in six to markedly enlarged in three; the heart sounds were good in six, poor in five and diminished in two. Congestive failure occurred in four. In six the pain was referred to both arms; in four to the left arm alone; in four to neither arm; and in none to the right arm alone. The electrocardiogram showed auriculoventricular block in two cases, intraventricular block in two, and low voltage in four.

Angina pectoris followed the coronary thrombosis in five cases; in only two did it precede it, in striking contrast to a considerable percentage (76 per cent) of 125 cases with angina pectoris among the 200 patients of all ages with coronary thrombosis.

Only three of the patients have died. The duration of life from the coronary thrombosis to death in these cases was five years, four and one-half years, and one and one-sixth years respectively; the death was sudden in two and with congestive failure following a second coronary thrombosis in one. Of the remaining eleven cases, nine are in good health after seven, six and one-half, six, four and two-thirds, two and three-fourths, two and two-thirds, five-sixths, and one-half years respectively, while the tenth and eleventh cases have been suffering from angina pectoris during the five years and five months respectively since their coronary thrombosis.

In contrast to these findings are a more than 50 per cent mortality over the same period of time in the large group of 200 cases of all ages, with an average duration of 1.5 years to death, as compared to 3.6 years for the young cases; and the average of 3.2 years to date for the survivors in contrast to 4.2 years for the young cases.

An additional group of seven young men with coronary thrombosis from recent records of my associate, Dr. Howard B. Sprague, and of the Massachusetts General Hospital, has also been analyzed by Dr. Glendy and myself. The data are much the same. All were male. Their ages at the time of the coronary thrombosis were 31, 35, 37, 38, 38, 39 and 39 years respectively. Four of the seven had no angina pectoris of paroxysmal nature; the other three had had angina pectoris eight months, one year and two years respectively before the coronary thrombosis. All were of English stock, except two who were Irish and Italian in origin. Three were in business, one a painter, two police officers, and one a superintendent of grounds. They lived in cities or small towns. Two were heavily built. Three had smoked heavily; two used alcohol moderately, three not at all. Three exercised little, the other four moderately. Serious infections in the past were rare—one had had diphtheria and one pneumonia. The family history was not remarkable. Hypertension was absent in all. Four showed cardiac enlargement after their coronary thrombosis and two congestive failure. Pain was referred to the left arm in three cases and to both arms in four. Electrocardiograms showed abnormal T waves in lead 1 or lead 2 in five; right bundle branch block in one; one case was not electrocardiographed. Six of these seven patients were getting on well when last heard from months to years after their acute illness; the seventh case died during his acute illness.

DATA OF OUR 14 CASES OF ANGINA PECTORIS UNDER THE AGE OF 40 YEARS

All were males, in contrast to 75 per cent males of a series of 500 cases of angina pectoris of all ages analyzed by Dr. Bland and myself.[29] There was only one under 35; we have excluded the very young cases of aortic regurgitation; only two cases were under 37.

Eight races were represented; five cases were of English stock, two of Irish, and the rest scattered.

Occupations included business in five, medicine in two, dentistry in one, music in one, sculpture in one, police in one, and three were artisans.

In build four were stocky; seven were average; and three were small or thin; none were fat.

Ten were of nervous temperament. All used tobacco, eight to excess. Nine took little or no alcohol. Exercise and bowel habits varied widely. Past history of infections was not striking; one case had had scarlet fever, one pneumonia, three gonorrhea, five influenza, and two tonsillitis. Family history was good or excellent in half (seven).

Hypertension was present in only one case, in contrast to 36.4 per cent of the large series of 500 cases of angina pectoris of all ages. Diabetes was present in one case. The heart size and sounds varied widely. Congestive failure occurred in only two. The pain was referred to both arms in eight of the fourteen, to the left arm alone in three, to neither arm in three, and to the right arm alone in none. The electrocardiogram showed auriculoventricular block in two cases and intraventricular block in two.

Coronary thrombosis antedated the angina pectoris in five cases, and followed in two.

Six cases have died, four suddenly; the duration to death was respectively twelve, nine and one-half, six and one-half, five, four, and one and one-sixth years,—an average of 6.4 years in contrast with an average duration of 4.4 years in 213 fatal cases of 500 patients of all ages with angina pectoris. Of the eight young survivors the duration of life to date averages 3.4 years in contrast to 5.1 years of the large group.

One may add a word in passing about the three cases of angina pectoris already referred to in the additional group of seven cases of coronary thrombosis. They were all male, 36, 36, and 38 years old respectively at the time of onset of their angina pectoris. One died of coronary thrombosis after two years. The other two survived their attacks of coronary thrombosis and are now fairly well. None were hypertensive or diabetic. They smoked moderately. Their family history was unimportant.

DATA ON CASES OF CORONARY THROMBOSIS AND ANGINA PECTORIS WITHOUT SYPHILIS OR VALVULAR DISEASE UNDER THE AGE OF 50 YEARS

Finally, I shall present some of the data of all of our cases of coronary thrombosis and of angina pectoris without syphilis or valvular disease who were under the age of 50 years. There were 138 of these out of a total of 1201 of all ages. Seventy-one had coronary thrombosis as compared to 418 of all ages; 118 had angina pectoris in contrast to 976 of all ages; 51 had both coronary thrombosis and angina pectoris in contrast to 193 of all ages. Four of the 138 were under the age of 30,—all had coronary thrombosis alone; twenty-one were under the age of 40,—these I have already discussed; 117 were between 40 and 50. Males far outnumbered females by almost 10 to 1—125 males and 13 females. Only 18 had hypertension, relatively far fewer than in the total series of all ages; a very significant point is that 11 of these 18 hypertensive cases were women—that is almost all the women had hypertension while only seven of the 125 males were similarly affected.

Heart size and sounds varied widely; in one-half the heart was not enlarged and in more than half the sounds were good. More often there was radiation of the pain to both arms (59) than to the left arm alone (33) or to neither arm (43); in only three instances was the pain referred to the right arm alone from the substernal region. In only three cases out of 128 electrocardiographed was there auriculoventricular block and in only eleven bundle branch block, full or partial. The T wave of lead 1 or lead 2 was frequently inverted (39). Only one case showed auricular fibrillation. In nineteen of the 128 cases electrocardiographed nothing abnormal was found by any method of examination.

Fifty-seven of the 138 cases are known to have died; the time elapsed from onset to death averaged 5.5 years, with considerably longer time, 6.1 years (with limits of four months to twenty-two years) in the case of those whose onset was with angina pectoris than the 3.9 years (with limits of three months

and eleven years) in the case of those whose onset was with coronary thrombosis.

Twenty-one of the 57 cases died suddenly without warning; fifteen more died from coronary thrombosis, seven from congestive failure; and four cardiac deaths were of unknown nature; two died from embolism, one from cerebral hemorrhage, two from suicide, and in the remaining five cases the cause of death was unknown.

Of the 57 cases known still to be alive, the average duration of life since the onset of trouble is seven years, with limits of six months and sixteen years.

Thus, the longevity after the onset of either coronary thrombosis or angina pectoris under the age of 50 is considerably greater than that in the cases of all ages, and hence much greater than in those over 50 years. This is, however, but slight consolation for acquiring coronary thrombosis or angina pectoris in youth.

COMPARISON OF 200 AGED INDIVIDUALS WITH 40 CASES OF ANGINA PECTORIS UNDER 50 YEARS OF AGE

When we turn to our series of healthy old men and women and compare them in race, occupation, build, residence, nervous strain, use of tobacco and alcohol, diet, exercise, past history of infections, and familial longevity, with the group of cases with coronary disease under the age of 50 years, we find only a few prominent differences, and these we must not unduly emphasize until we have information from many more cases than we have at present. We have as yet reasonably satisfactory data from only 200 old persons, and from only 40 young coronary disease patients.

The differences in these two groups that stand out to date are as follows: Relatively far more of the old group 80, 90, and 100 years old are of British stock with rare members of other races than is true of the young coronary group; but here selection and other factors like time of immigration may well enter in and we are now investigating that point and looking for aged persons of non-British ancestry.

Very few of the old men and women are fat but the same is true of the young coronary cases.

The majority of the old group have resided in town and country in contrast to the young group whose residence has been almost wholly in large cities. Nervous sensitiveness and strain have been considerably greater in the young group. The old folks have used far less tobacco relatively and there have been many total abstainers from both tobacco and alcohol in contrast to the young coronary cases.

The older group claims to have eaten more moderately than the younger group, but here a difficulty arises in that a man one hundred years old whose diet is almost always frugal may have forgotten the days of seventy-five years before when he had probably a big appetite. Of late it has been suggested that certain foods rich in cholesterol, chiefly eggs, milk, and butter eaten in adult life in excess may be a factor in the production of atherosclerosis; in our two series it is true that somewhat more eggs and milk were apparently consumed by the young coronary cases than by the old folks but many of the aged who are still well and active have stated that they had consumed eggs and milk regularly every day of their lives.

As for exercise, it was a much more constant feature in the older group, many of whom had worked hard outdoors on their farms for almost countless years; however, there are exceptions in both groups.

When we come to the past history of infections we are at first surprised to discover that the older group suffered considerably more from severe infections of all sorts than did the younger; for example, typhoid fever, malaria, and even smallpox were not at all uncommon in the older cases while they were nonexistent in the younger. It was also of interest that rheumatic fever and even tonsillitis occurred infrequently in the young group.

Finally the total immediate ancestral longevity (Pearl's TIAL) was greater, as we would at the very beginning expect, in the older group than in the younger, the average age of father and mother and the four grandparents being something over 73 years in the case of the old folks and a little over 68 years in the young; this difference, however, is not as great as we would have thought it should

be, but the hazards of life in the way of serious infections of youth were greater in olden days and killed off at an early age some of the immediate ancestors of the old group. Many of the young coronary disease cases had good immediate ancestral health and longevity but there were more in this group than in the group of old individuals whose grandparents, fathers and brothers died cardiac deaths young. Only rarely, however, is there such an instance as that reported by Herapath and Perry,[30] the case of a man who died suddenly of coronary disease at 43 whose father had died suddenly at 42 and whose brothers had also died sudden heart deaths at 30 and 31 respectively.

COMMENT AND CONCLUSION

What may we conclude from all this? Not very much, I'm afraid, about the cause of coronary disease or atherosclerosis. I attended last summer the meeting of the International Association of Geographic Pathologists at Utrecht,[31] Holland, and listened to the discussion on arteriosclerosis which was the topic of the congress. It was impressive to realize there how little we know about the fundamental cause of atherosclerosis of the coronary as well as the other arteries. The consensus of opinion seemed to be that for some reason or other, perhaps a metabolic one, fat is laid down in the arterial intima in such amounts that it cannot be taken up again quickly; and its presence excites a reaction of fibrosis and in older individuals so-called atheromatous abscesses and calcification. Thrombosis may occur in either young or old but more readily in the old. The fat depositions and fibrosis are most commonly found in regions of particular stress, such as the beginning of the anterior descending branch of the left coronary artery.

There remained only a minority of the pathologists who supported the infectious origin. Arteriosclerosis of the coronary arteries was reported to be widely scattered throughout the world, but less in certain so-called exotic countries like Java, Chile, and Puerto Rico. There was said to be very little angina pectoris in natives in Java, and we know that it occurs rarely if at all among full-blooded negroes. But as I have already said, coronary disease and angina pectoris are different things; there may be much of either without the other.

Our own findings in the young coronary disease cases afford certain clues, which may eventually prove helpful in the analysis of causes and in prevention. These are, in brief, as follows:

The *male* sex is overwhelmingly the victim in early life; this is perhaps the outstanding clue.

The young cases of my series all used considerable *tobacco;* this fact is an exception to the findings that I reported some time ago on the relationship of angina pectoris to the use of tobacco and alcohol.[32] A series of 750 cases of angina pectoris of all ages compared to a series of 750 individuals without angina pectoris of the same ages, proportion of the sexes, and walks of life showed relatively little difference in their past use of tobacco and alcohol; some individual exceptions were noted. Now it would rather appear that the youngest cases may fall among the exceptions.

One very interesting observation recently made by Dr. Starr,[33] of Hartford, which provokes serious thought and which has caused us to carry out further studies is the finding of inversion of the T waves in lead 2 of the electrocardiogram during the inhalation of tobacco smoke in a young man 18 years old who had reported that such inhalation made him feel badly and slightly dizzy (though without any substernal oppression). It is possible that such a reaction occurs in occasional cases; we are now looking into it.

The question of ancestral longevity and inheritance is undoubtedly important. Our data give some support to the widely held notion that it is of fundamental importance to inherit long lived ancestors. How much we may be able eventually to overcome faulty arterial inheritance by measures of hygiene and so on, remains for us and our successors to determine.

Two other points of some interest concerning our young coronary cases are that they live *city lives* and have not exercised consistently.

Infections do not seem to play much of a

rôle in the production of serious coronary disease, according to our findings to date. Nor does diet, although further study may show that as in diabetes, it is the combination of faulty metabolism plus faulty diet that is important.

Assuredly the subject is a very important and interesting one, and further clues from any source or method of approach may aid in the eventual solution of the problem.

I wish to acknowledge with gratitude the invaluable aid rendered by Dr. R. Earle Glendy in the assembly of much of the data used in the preparation of this paper. We shall together present a full report of our more complete studies on this subject at a later date.

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THE TREATMENT OF CERTAIN VASCULAR COMPLICATIONS IN DIABETES MELLITUS

By Albert A. Epstein, M.D., New York City

An abstract of a paper read before the Section of Medicine and Pediatrics of the Academy of Medicine of Northern New Jersey, on October 9, 1934, in Newark

Dr. Epstein opened his talk with a brief consideration of the normal and pathologic physiology of the circulation of the lower extremity. He described the arterial flow, the venous return, and the collateral circulation. The most important factor in normal circulation is the presence of adequate venous channels, so that the veins are really an expression of the arterial blood supply.

The oscillometer, so frequently used to determine lower limb circulatory efficiency, is inaccurate and confusing for it does not demonstrate collateral circulation, and because extensive gangrene may be present even when important arteries are patent.

In varicosities and thrombophlebitis of the lower extremity, a loss of normal venous response occurs, so that the increased back pressure of the excess blood encourages the formation of collateral circulation. Therefore, gangrene never occurs in the diabetic in whom thrombophlebitis is present.

As a means of encouraging good collateral circulation, Dr. Epstein suggested the usage of constricting bands in the mid-thigh to impede the venous return.

Dr. Epstein next demonstrated a method of studying circulatory efficiency by the raising and the lowering of the leg, and observing the filling of the veins. This method, he feels, is the one from which the surgeon or clinician may derive most information as to whether or not surgical intervention is indicated.

SURGERY IN DIABETICS

Next, Dr. Epstein considered certain surgical aspects of diabetes mellitus from the viewpoint of the internist. Diabetic patients are particularly prone to infections, but the course of an infection in a diabetic is usually milder than in a non-diabetic patient. His explanation is that the presence of a hyperglycemia tends to so decrease the virulence of the pathogenic organism so that it assumes the relatively harmless rôle of a saprophyte. Therefore, he does not undertake active and heroic desugarizing measures in the presence of an infection in a diabetic. He permits, for example, no surgical procedures in a diabetic carbuncle, as he strongly feels that procrastination assures better results. He agrees, however, that diabetes mellitus, *per se,* is aggravated by an infection because the toxin tends to neutralize insulin, and also because the patient's basal metabolic rate is raised.

Surgery in diabetes resolves itself into two categories: 1, Cases in which the surgery is elective, as in a chronic cholecystitis; 2, cases in which an emergency exists as in an acute appendicitis.

The preoperative treatment of any diabetic is not very important as overtreatment may bring about a hypoglycemia which in the course of the use of a general anesthesia may lead to a fatality. Dr. Epstein feels that a slight glycosuria in the course of an operation should be comforting to the surgeon. However, he believes in meticulous post-operative diabetic care. He gives insulin in small doses and often being guided as to the dosage by blood sugar rather than urinary sugar determinations.

The speaker felt that the stress that has been placed upon the perverted fat metabolism in diabetes mellitus as a cause for arteriosclerosis, is erroneous. He inclines rather to the thought that a combination of effects from very many and diverse chemical products is the cause.

Gangrene in diabetes is divided into two types, i. e.:

1. Vascular, which is of the same type is found in non-diabetiecs.

2. Traumatic, where the diabetic condition has a necrotizing effect upon the locally infected or injured tissues.

Infections in diabetics, Dr. Epstein pointed out, are really brought about by circulatory failure, and thus the increase in infections in the later age groups is explained.

STATE SOCIETY ACTIVITIES

CHARTS OF FUNCTIONS AND ORGANIZATION OF THE MEDICAL SOCIETY OF NEW JERSEY

By LeRoy A. Wilkes, M.D., Executive Officer,
and
Frank Overton, M.D., Dr. P.H., Editor.
137 East State Street, Trenton, N. J.

This article consists of comments on a series of charts which were shown at the annual meeting of The Medical Society of New Jersey, April 30 to May 2, 1935, in Atlantic City, N. J., and at the joint meeting of the American Medical Association and the Canadian Medical Association, June 11-14, 1935, in Atlantic City, N. J. The comments were based on the experience of the authors in conferring with visitors to the exhibit booth who asked questions regarding the functions and organization of The Medical Society of New Jersey and later wrote for further information regarding its methods of work and the results attained. They will also help the members of The Medical Society of New Jersey to clarify their own knowledge and impressions of the functions and organization of their Society.

1. GENERAL CONSIDERATIONS

The Medical Society of New Jersey has an individuality which may be expressed in charts of its functions and its organization. Its general plan of organization is similar to that of the societies of other states and of the counties; but variations in the details of the organization enable the Society to function with ease and efficiency. In devising the following charts, *function* has been a dominant consideration around which the *form* of organization has been built.

PERSONIFYING THE MEDICAL SOCIETY

The term *Medical Society* has been an impersonal abstraction until very recent years. That of New Jersey, now in its 169th year,—the oldest of all State Societies,—remained largely an abstraction for over a century, arousing little enthusiasm, and exercising a restricted influence except in times of emergency. But during the last half century, and especially the last two decades, it has shown an ever increasing degree of activity in exemplifying the good qualities and aspirations of its individual members. It has developed a *soul* that senses human suffering, a *conscience* that seeks the proper remedy, and a *heart* that arouses emotion so that a member speaks of it as "my society", just as he says "my family", or "my church".

The Medical Society extends its services beyond its own circle of members. It is the *medical adviser to the community,* just as the family doctor is the personal physician to a sick individual. The Medical Society of New Jersey urges lay health organizations to consult the County Medical Society for advice at the inception of every health project, just as a parent calls the doctor to a sick child.

The State Society sends representatives to every lay health conference whose leaders recognize the essential need of medical judgment and advice. Invitations to these conferences are received by the State Society with increasing frequency, and are always accepted.

These are examples of Society services that would be classed as *personal practice* if they were done by an individual physician.

BASIC METHODS

A Medical Society works through its individual officers, who determine its personality, its efficiency, and its reputation. It is operated in accordance with written rules and codes of procedure which may be the refuge of officers who are timid, or the justification of those who are formal and assertive in their leadership. But the leaders of The Medical Society of New Jersey have always been progressive in their alertness to recognize and supply the medical needs of the people; and at the same time they have been conservative in their policy to "Prove all things; hold fast that which is good". The Society has developed and perfected its form of organization by adapting its methods to changing conditions.

After a new objective or policy has been adopted, the Society deals with it in three steps:

1. By assigning it to a committee to study the problem and to devise a method for its solution.

2. By the committee duplicating itself in the twenty-one County Societies, each of which develops the solution adapted to its own community.

3. By the State Committee following up the project in each county; and advising and inspiring the members of the local committees, and assisting them in the details of their problem.

TABLE OF STEPS IN THE DEVELOPMENT OF A SERVICE

Stage of Development	*By Whom Done*
1. An objective outlined	House of Delegates, or Trustees
2. A policy stated	Trustees, or Welfare Committee, or President
3. A project and method planned	A State Committee
4. Co-operation promoted	County Society Committees,—The State Committee duplicated in 21 Societies
5. Service delivered	Individual members—3000

The peculiar efficiency of the New Jersey method of dealing with a new problem is the result of the established policy of the State Society that it does not stop after passing a resolution approving a plan of action; but its officers maintain their interest in the project until it has been seriously considered by every one of its component county societies.

EMERGENCY RELIEF ADMINISTRATION

The custom of the State Society of "following through" every activity that it undertakes is illustrated by its method of giving medical relief to the indigent. When the Federal Law of relief was put into operation in the Spring of 1933, the officers of the State Society at once offered their services to the State Relief Administration; and in July the two organizations had completed the agreements which have been carried out for two years with marked success. The essential features of the plan are as follows:

1. A committee of the State Society confers regularly with the executive officers of the government.

2. A committee of each County Society confers with the County Relief Director.

3. Local physicians treat the indigent sick on the authorization of the County or Municipal Directors.

4. The physician sends his bill to his County Medical Committee for audit and approval.

5. The State E. R. A. pays the approved bill to the physician rendering the service.

Many details have required clarification, and threatened disputes have been settled by a mutual spirit of wise adaptations. The strong feature of the project is the initiative and leadership of The Medical Society of New Jersey in devising and operating a satisfactory plan of medical relief to the indigent.

GEOGRAPHIC ADVANTAGES

Geographic conditions of the State of New Jersey are peculiarly favorable to the development of its State Medical Society to a high degree of efficiency.

1. It is located between two great medical centers, New York and Philadelphia, ninety miles apart, each having an adjoining metropolitan area which in itself is an important medical center.

2. The State has a length of 200 miles, with both the capital, Trenton, and the metropolis, Newark, midway between the extremities, and readily accessible by automobile. Members may make their calls in the morning, attend a meeting in Trenton or Newark in the afternoon, and return in the evening.

There are the additional advantages of a varying density of its population of 4,000,000, and a diversity of occupations, from great manufacturing industries to farming, and from mining in the northern hills to seafaring along the extensive coast line.

The frequent contacts of city dwellers with rural folk in New Jersey result in a mutual respect of the members of two groups for one another. The suggestions of health organizations are understood and appreciated in the rural counties; while the city leaders benefit through the *personal* acquaintances and contacts characteristic of the county districts. New Jersey shows an unusual degree of coöperation between the authorities of the *city* and the *country* in all lines of civic activities, especially when medical problems are involved.

All these considerations tend to unite the physicians of New Jersey into a great family, with varied contacts and broad sympathies which are manifest in a large degree of medical comradeship and leadership.

2. EXECUTIVE OFFICES

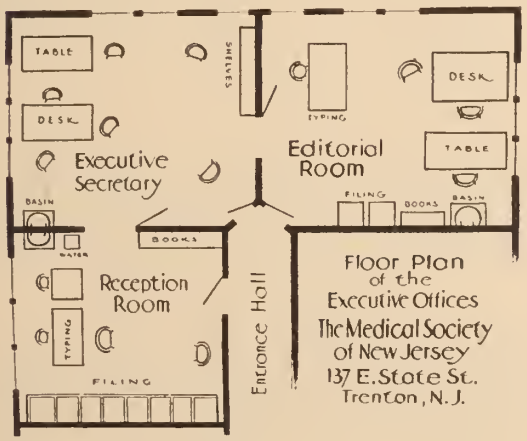
CHART 1.

The Medical Society of New Jersey is a corporation whose influence and usefulness depend on three physical factors:

1. Its officers and committees.
2. Its staff of full-time workers.
3. Its executive offices.

The Society existed and prospered for more than a century and a half while its work was carried on by a few officers who donated their services and paid their own expenses. Honor for past services as well as fitness for future duties was an important consideration in the choice of leaders. The projects that were undertaken were limited in scope, for medical services consisted almost entirely in the private contact of an individual doctor with an individual sick person, and the physician felt that the Society could give him little direct help. The terms of the officers were usually brief, and frequent changes in personnel hindered the extension of the influence of the Society beyond its own members.

CHART 1



The broadening of the field of scientific medicine and the rise of preventive services brought new opportunities and responsibilities to the physicians both individually and as a group; and led to the employment of a full-time Secretary-Editor, with some clerical assistance. This progressive step, taken in 1924, made sustained action possible by both the officers and the members of the Society, and demonstrated the essential value of the leadership of the Society in contacts with lay health agencies and with its members. The appreciation of physicians with the centralized organization was shown by a great increase in the number of members and in their support of the policies of the Society.

CENTRALIZED EXECUTIVE OFFICES

The inauguration of new activities and the increase in the number of committees necessary to carry out the projects led inevitably to the establishment of headquarters to be the Executive Offices of the Society where all records are received and classified, and from which information on all Society matters are sent to the members. The Executive Offices are also the center from which contacts are made with non-medical agencies assisting in the distribution of medical services and the promotion of physical health and vigor.

The Executive Offices were established in the Fall of 1933, in Trenton. The rooms are simply furnished with flat-topped desks and tables, and with filing cabinets, and book cases, typewriting machines, a dictaphone, and outfits for mimeographing. An additional room is used for storage and for mechanical work.

PERSONNEL AND ACTIVITIES

The work of the headquarters is carried on and directed by two full-time physicians,—the Executive Officer, and the Editor,—both experienced in the three essential lines of private practice, public health, and executive management. They are assisted by three stenographers who, in the absence of the executives, have the temperament and ability to deal with the officers and members of the Society and with inquiries from lay organizations.

The work done in the headquarters does not supplant or interfere with that of the officers in any way; but on the other hand it relieves them of the routine work of collecting, classifying, and issuing information.

COUNTY SOCIETY HEADQUARTERS

The next logical development will be that each County Society shall set up its own headquarters, as the two largest counties, Essex and Hudson, have already done. Even the smallest counties can have an address, a telephone number, and office hours when the Secretary or his representative may be called.

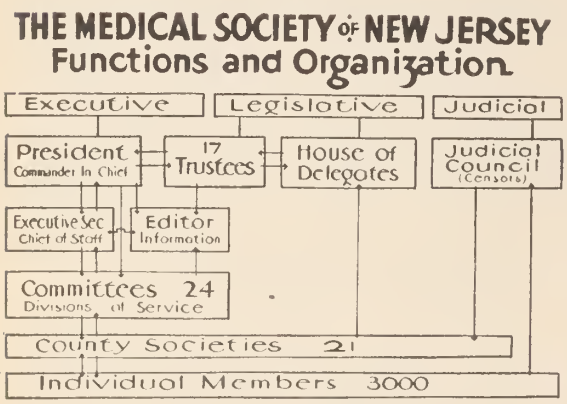
The active participation of every County Society in State Society activities is essential for unity and efficiency in the practice of civic medicine. The responsiveness of the executive officers of a County Society to communications is an index of the activity of the organization; and determines its influence on both its members and the laity.

3. FUNCTIONS AND ORGANIZATION OF THE STATE SOCIETY

CHART 2

The Medical Society of New Jersey is organized around three functions,—executive, legislative, and judicial.

CHART 2



JUDICIAL FUNCTIONS

The judicial functions are carried on by a *Judicial Council* of five Councilors, elected by the House of Delegates,—one from each of the five districts into which the twenty-one County Soeieties are grouped. The Councilors compose the Board of Censors, in charge of ethics and discipline,—and it is to the credit of the physicians of New Jersey that the Board seldom has to perform any duty of discipline.

The important duty of each Councilor is to act as an adviser to the County Societies of his district,—to visit them, to hold a meeting of them once a year, and to assist the officers in their support of the projects of the Society.

HOUSE OF DELEGATES

The legislative function of The Medical Society of New Jersey is vested in the House of Delegates, which in 1935 had the following composition:

Officers of the State Society	22
Past Presidents of the Society	15
Elected Delegates (one to each 15 members)	207
Total	244

The House of Delegates meets once a year and is the center around which the Annual Meeting of the State Society is planned. Its principal functions are to receive and act upon the reports of all the officers and committees of the State Society, and to elect the officers of the Society.

The method of procedure of the House of Delegates has been evolved from years of experience, and is as follows:

1. The reports of all officers and committees of the Society are prepared and published in the monthly Journal of the Society, one month in advance of the meeting, so that every delegate and member can read and digest them before he comes to the Annual Meeting. By this method there is no need that the reports be read at the Annual Meeting, and so the transaction of business is facilitated.

2. Reference Committees are appointed from among the Delegates, and the reports are assigned to them for study and for recommending the action to be taken by the House of Delegates. The personnel of the committees is published in the journal along with the annual reports.

3. Each Reference Committee is ready to receive comments and suggestions before the Annual Meeting. It also has a room assigned to it during the Annual Meeting where any member may address the committee and be assured a respectful hearing, thereby avoiding long debates on minor subjects on the floor of the House.

4. The action by the House on all the more important subjects is based on the reports of the Reference Committees.

This method of procedure assures an opportunity for every member of the Society to be heard, and it promotes good judgment and efficiency in the transaction of business.

BOARD OF TRUSTEES

The function of legislation is assigned to the Board of Trustees during the interim between the Annual Meetings, subject to the approval of the next House of Delegates. The Board consists of seventeen members composed of the six principal officers of the Society, two Past Presidents, and nine members elected for three years for overlapping terms.

The Trustees also perform the *executive* duty of determining the methods of carrying out the broad policies of the State Society, and allocating its funds to its officers and committees. Provision for the election of at least two Past Presidents as Trustees, and frequent meetings of the Board insure stability and wisdom in the administration of the affairs of the Society.

OFFICERS AND COMMITTEES

The affairs of The Medical Society of New Jersey are administered by its officers and committes, subject to the oversight of the Trustees and the rulings of the House of Delegates. A valuable feature of the organization is the "Welfare Committee", composed of thirty-five members on which every County Society is represented. This Committee has "supervision over legislative matters, public health, and public relations". It acts principally through subcommittees and special committees whose activities it coördinates and directs. Through it the Society is enabled to take action promptly and authoritatively when a new condition arises.

It is the policy of the Society that the number of committees and their personnel shall be sufficiently large to permit the members to perform their duties promptly and efficiently, and with a reasonable expenditure of time and effort. The list of the personnel of the officers and committees contains the names of 175 members of the State Society, or six per cent of the membership. One in every sixteen members of the State Society is actively engaged in performing its executive functions.

A large number of officers and committeemen is also required by the component county societies in order to carry out the projects of the State Society, and to administer their own affairs. The list of the personnel of the county societies compiled in February, 1935, contained over 900 names, or 33 per cent of the membership of the State Society. One out of every three members of the State Society therefore holds an official position, and is directly responsible for the administration of its affairs.

THE PRESIDENT

By action of the Board of Trustees and the House of Delegates taken in 1933 and 1934, a plan was unanimously adopted "To make the Society with all its activities revolve around the President during the year of his presidency" (Journal, May, 1934, page 263). The object of this action is to unify and coördinate the activities of the officers and committees, and to endow the presidency with responsibility as well as honor.

The President is prepared for his duties by the unwritten custom to advance an aspirant to the office through the grades of second and first vice-president, and president-elect, and to assign these officers to chairmanships of important committees so that they are experienced in society administration when they reach the presidency.

4. FUNCTIONS AND CONTACTS OF THE EXECUTIVE OFFICES

CHART 3

It is comparatively easy for the leaders of a State Medical Society to *plan* a project; to *sell* it to the County Societies is hard; but it is still more difficult to inspire the members to *use* the plan in their daily practice.

A medical society is efficient to the degree that intimate contacts of leaders with the members lead to mutual understandings. The Medical Society of New Jersey in its early days diagnosed many social ills, and suggested lines of treatment which were not carried out because the leaders lacked the means of instructing and interesting the members. The establishment of Executive Offices in 1933 enabled its officers and committeemen to maintain close contact with one another, with the County Societies, and with the individual members. These contacts are made in four ways:

1. At meetings of the State Committees and of the County Societies.
2. By personal visits.
3. By mail and telephone.
4. Through The Journal.

While the contacts of the State Society are under the supervision of the President, their details are carried out by the Executive Officer, who is his Chief Aide, and by the Editor. These two executives have charge of the activities of the Executive Offices.

The Executive Officer performs three groups of duties:

1. Administration and communications.
2. Advisory in plans and operations.
3. Legislative supervision.

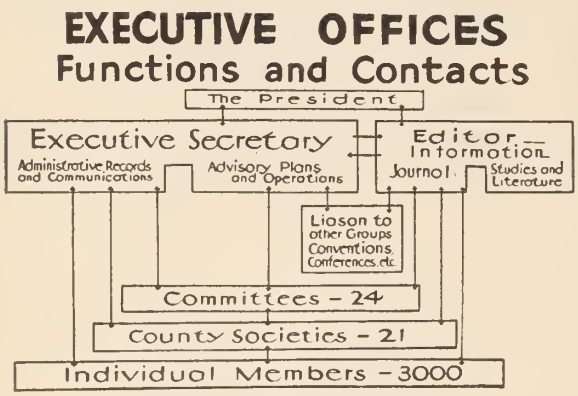
His contacts and duties may be classed as *personal.*

The contacts and functions of the Editor may be classed as *impersonal* and *historical.* He takes the information which flows through the Executive Offices, and prepares it for publication in the monthly journal of the State Society, thereby bringing it to every officer and member as a permanent record. The peculiar value of The Journal is that it is the most complete and most available source of information concerning the activities of the State Society and the County Societies.

The functions of the two executives might be carried on by a single individual in the smaller states; but their efficiency in the larger

societies such as that of New Jersey, requires the full time of two persons. Harmony of action of the two executives in New Jersey is secured by an observance in the time element in the natural development of an activity, and the natural sequence in carrying it out. The Executive Officer attends to the *immediate details* of current business and activities; while the Editor is concerned with classifying and publishing the records of *results* attained. The work of each executive is complementary to that of the other.

CHART 3



An almost complete change in the personnel of officers and committees takes place every five years, and incoming officers are likely to propose plans which to them are novel, but which were discussed in the Journals of the past years. An important function of both the Editor and the Executive Officer of The Medical Society of New Jersey is to consult the records, and to suggest means by which the experiences of past years may be made available to the present officers and committees.

CONTACTS WITH LAY HEALTH ORGANIZATIONS

An important function of the Executive Officer and the Editor is to carry out the policy of the State Society to establish contacts with health organizations, both official and lay. These contacts have already resulted in better understandings and greater coöperation between the medical profession and the lay groups, as is demonstrated in the two projects of the Emergency Relief Administration, and the Public Health Hour. The necessity and usefulness of these contacts are evident when one considers the nation-wide proposals for health insurance under governmental control.

The Medical Society of New Jersey urges every local health organization to look to the Medical Society of its county for advice and coöperation in establishing any local health project. It is equally insistent that the County Society shall respond to these calls for advice and assistance, and to offer the service of the medical profesion if it is not sought.

5. LEGISLATION

CHART 4

One of the major functions of every State Medical Society is that of advising the members of the Legislature regarding proposed bills which affect health. Selfish measures are often supported by powerful groups of propagandists varying from self-seeking cultists to militant reformers. On the other hand, legislators may permit health measures to fail because of the inaction of medical men who believe that truth generates its own power for prevailing. The Medical Society of New Jersey has been active in its contacts with the Legislature, and efficient in securing the respect and support of the legislators.

The Medical Society has ignored as beneath its notice the assertion of the cultists who say that physicians are actuated by selfish motives in suggesting medical legislation, in that they will profit financially by the elimination of the competition of those untrained in scientific medicine, and by the creation of new positions in public health services. Replying to these assertions and insinuations would be a recognition of the power and importance of the cultists.

The Medical Society of New Jersey does not recognize politics in any way in its contacts with the Legislature. It does not attempt to influence the nomination or election of a particular legislator. A candidate who disapproves a particular medical project may approve other projects that come up for consideration. It is good psychology to assume that every candidate is a man of good judgment and will give serious consideration to every medical project.

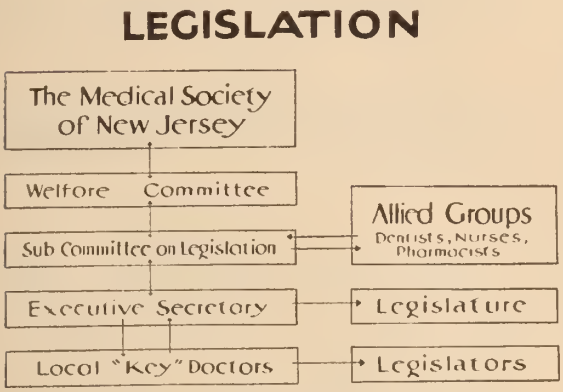
When the Legislature meets, The Medical Society of New Jersey tacitly compliments every Legislator by appealing to his knowledge and good judgment unfettered by preëlection promises whose nature and implications he did not comprehend. The Legislators respect the disinterested opinions of the medical and allied

groups, when they are presented at the proper time.

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

The Medical Society of New Jersey maintains a contact with the dentists, nurses, and pharmacists, through an organization known as

CHART 4



the *Conference of Allied Medical Professions,* one of whose functions is to act on legislative matters affecting the four groups, as do many bills. The number of votes influenced by these four groups aggregates many thousands.

THE EXECUTIVE OFFICER

The Medical Society maintains a close contact with the Legislators through its Executive Officer, who attends all meetings of the Legislature as the representative of the Committee on Legislation. He does not use the methods of the lobbyist, but utilizes the sources of information that are available to every public-spirited citizen.

KEY MEN

The essential feature of the Society's plan to influence the individual Legislators is that direct approaches to them are made *in their homes,* by "key men". Each key man is a physician who is intimately acquainted with the Legislator from his home district. His duty is to ascertain the attitude of his legislative friend toward every bill as it comes up for consideration. The key man reports to the Executive Officer, who is thereby informed of the attitude of every Legislator.

If arguments are necessary for the instruction of a legislator, they are presented to him quietly by a committee of the Medical Society of his County, without publicity. If a formal hearing is held on a medical bill, the Committee on Legislation presents the arguments of the Medical Profession, knowing that practically every legislator has already received information from a key man.

The system of key men functions in a manner which wins and maintains the confidence of the members of the Legislature, and the dignity of the medical profession and the legislators.

6. THE PUBLIC HEALTH HOUR

CHART 5

The Public Health Hour is a state-wide project, instituted in the Fall of 1933 by The Medical Society of New Jersey, for the purpose of enlisting the family doctors in the work of giving the services of *preventive medicine* to their private patients, especially the immunization of children. The plan is based on that which Dr. Henry Vaughan, Commissioner of Health of the City of Detroit, Michigan, successfully developed in order that physicians in private practice should give the immunizations in their offices, thereby eliminating the immunizing clinics which had been conducted by the Health Departments and Schools.

The plan of the Public Health Hour was devised by the Welfare Committee, and its administration was assigned to the Committee on Public Health, which operates through a similar committee in each County Society. The immunizations are now limited to those against diphtheria and smallpox.

METHOD OF OPERATION

The method of operation of the Public Health Hour project is as follows:

1. Each physician is urged to sign an agreement to coöperate with the committee.

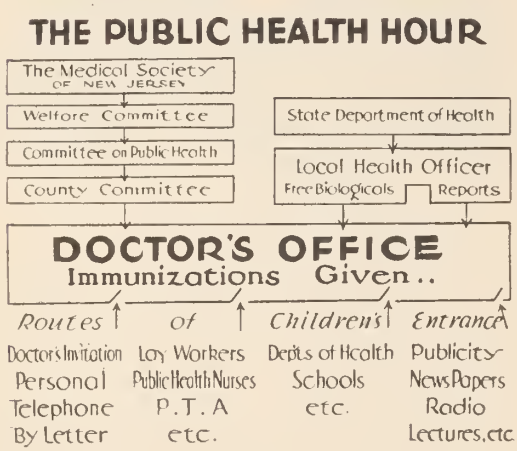
2. Each coöperating physician signs an agreement to set aside a Public Health Hour once a week when he will give the immunizations to patients at a special reduced price, or for no fee at all if the patient is unable to pay. This special fee does not apply to those patients who come during the doctor's regular office hours.

3. The State Department of Health supplies the immunizing material free to the cooperating physicians. The supply of biologicals is made possible through a special appropriation made by the Legislature for the purpose, with the understanding that none should be supplied free to clinics and schools.

4. Each doctor agrees to give the biologicals only to those patients coming during his Public Health Hour; and also to report their use to the State Department of Health.

5. The Medical Society of New Jersey supplied every coöperating physician with a placard to be displayed in his office window or

CHART 5



door, announcing the hour when he will receive patients under the terms of the project.

REACHING THE PATIENTS

When the project of the Public Health Hour was instituted, the coöperating physicians were in a position similar to that of a young doctor who is starting in practice. The physicians were ready to receive patients; but only a few came, for time was required for a knowledge of the service to reach those who needed it. Patients come for immunizations through four doors or avenues of approach:

1. The solicitation of parents by the physicians themselves.

2. Through lay public health workers,—such as public health nurses, and parent-teacher associations.

3. Through health departments and schools which had previously conducted free immunization clinics.

4. Through publicity by such means as newspapers, lectures, and the radio.

The ethics of the solicitation of patients by the practicing physicians was covered by the action of the State Society in approving the plan that each doctor should communicate with the heads of those families to whom he was the family doctor, by means of personal conversations, or by telephone, or a personal letter. The State Society, coöperating with the State Department of Health, supplied two forms to be used in writing to parents. The briefer form was as follows:

My Dear Mrs. ———:

Has your child been immunized against diphtheria or vaccinated against smallpox? You probably know that diphtheria, as well as smallpox, is preventable.

The New Jersey State and County Medical Societies have requested each physician to write to his patients in regard to this matter.

Coöperation of parents is most essential if we are to achieve our aim to eradicate these diseases. It is in this spirit that I, as your family physician, address this card to you. I suggest that you call at my office on ———.

——— ———, M.D.

ACCOMPLISHMENTS

Each issue of The Journal has carried a table supplied by the State Department of Health, stating the number of immunizations reported in each county during the previous month by the coöperating physicians. The total for the year ending June 30, 1935, recorded in The Journal of July, 1935, was as follows:

Diphtheria toxoid	18,676
Smallpox vaccine	9,811

This number is considerably less than those reported by public clinics which had been conducted under the auspices of lay organizations and schools; but the number is increasing, and is demonstrating the growing interest of the practicing physicians in the project.

The next logical step in promoting the Public Health Hour will be to secure the active coöperation of lay health organizations. It must be remembered that public immunizing clinics have an emotional appeal to their promotors, who organize a drive for patients, and make it a social event when patrons supply automobiles for transporting patients, provide free lunches for them, and enlist the services of public health nurses, school teachers, and volunteer workers for the day. It is prosaic for the laymen to send individuals to a physician's office without the stimulus of mass action followed by newspaper publicity, with write-ups and photographs of the participants. If the State and County Medical Societies secure the hearty coöperation of the lay health organizations, the Public Health Hour in New Jersey will accomplish the object for which immunizing clinics have been conducted.

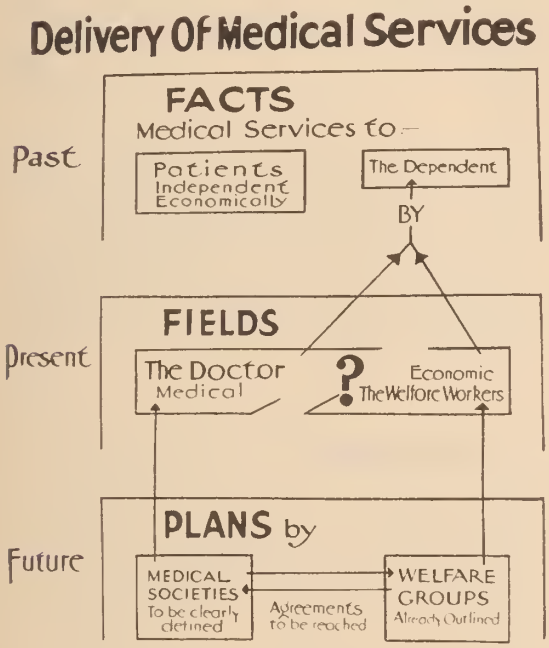
7. DELIVERY OF MEDICAL SERVICES

CHART 6

A discussion of medical services falls naturally into the two divisions of *production,* and *delivery.*

The *production* of medical services deals with scientific research and the medical education of physicians. The fundamental principles of research and education are the same now that they were in the past, and will continue to be in the future.

CHART 6



HISTORICAL DEVELOPMENT

The *delivery* of medical services was formerly a simple act made by the individual doctor directly to the individual sick person. It developed into a complex process, starting with the era of hospital building in the decades of the seventies and eighties, and involving nurses, laboratories and technicians, departments of health, welfare officials, and lay secretaries of great "foundations". These accessories were costly, and introduced the troublesome element of *economics* into medical practice. They also gave rise to the question of leadership, whether it should be by the Medical Profession, or by the subsidized personnel of the other groups.

The rise of the lay agencies in the practice of medicine was insidious and their implications were not forseen. Their activities were supported largely by voluntary contributions of both effort and money. Physicians were willing to make their contributions by donating their services in hospitals and clinics, until the money value of their free services equalled that of the other groups; and yet their contributions were accepted as a matter of course.

The newer system required the classification of patients according to their economic status into those *independent* financially, and the *dependent,* or those requiring assistance. It soon became necessary to recognize a third and large group composed of those who were independent and could pay for medical services under ordinary conditions, but who became partly or wholly dependent when sickness was unusually prolonged or severe. Who should compose the semi-independent class became a great source of dispute and misunderstanding. The question became especially troublesome in dispensaries and public hospitals, leading to charges that the institutions were competing with private practitioners.

PRESENT FIELDS OF PRACTICE

The field of medical practice at present is occupied by two groups of workers.

To the Medical Profession is conceded the actual delivery of purely medical services, for only a physician can practice medicine. To the lay groups belong duties connected with economics, but by no means all of them. The assignment of half of the field of practice is therefore in dispute. Experience has demonstrated the necessity that the overlapping fields of practice shall be clearly defined. This is what The Medical Society of New Jersey is trying to do.

FUTURE PLANS

The plans and objectives of the welfare groups have been stated publicly and fully; and if they are adopted, these groups will be dominant in all fields of economics.

The leaders of The Medical Society of New Jersey have adopted the policy of avoiding obstructive criticism of the economic plans of the welfare groups, and at the time they have quietly conducted an investigation of the medical needs of the State in medical lines, and made diagnoses of actual conditions under which the physicians practice medicine.

Furthermore, the medical leaders have consulted together and have made suggestions for the treatment of the unsatisfactory conditions by the application of methods tested by experience. The two state-wide projects of the Public Health Hour and the Emergency Relief Administration are already in successful operation and are prophetic of further projects which may be developed in the future.

DUTIES OF THE EXECUTIVE OFFICER

The development of the functions of the executive offices, and the great increase in the amount and number of the routine duties performed by the Executive Secretary, were noted in the last meeting of the House of Delegates in the report of the Reference Committee on the reports of the President, the Executive Secretary, the Board of Trustees, and the Secretary; and on motion of Dr. E. W. Sprague, Chairman of the Committee, the House voted to request the Board of Trustees to re-define the duties of the Executive Secretary. (Transactions 1935, pages 53 and 57.)

In conformity with this instruction, the Trustees took the following action at its meeting on September 22:

1. The title of the *Executive Secretary* shall be changed to *Executive Officer.*

2. In conformity with the declared policy of the Society that the affairs of the Society shall revolve around the President during his term of office, the Executive Officer shall be his *chief aide,* carrying into effect his policies.

3. He shall act as Secretary to the Welfare Committee, embracing legislative matters, medical practice, public health, public relations and all other matters referred to the Welfare Committee which are not specifically delegated to other committees (Standing and Special Committees). During the legislative session, legislation in which the Society is interested shall be paramount.

4. In the Executive Offices and in the field he shall integrate the activities of the Officers and the Committee members in the State and County Societies.

5. He shall be available at all meetings of the Board of Trustees when his presence is required.

The Trustees also passed the following resolution:

All committees, except the Welfare Committee, shall elect a secretary, and minutes of all committee meetings shall be kept and a certified copy forwarded promptly to the Executive Officer of the Society after each meeting.

The Trustees also decided that the next Annual Meeting should be held June 2-4, 1936, in Atlantic City.

SURVEY OF FAMILIES ON RELIEF

The Emergency Relief Administration of the State of New Jersey has made a survey of 10,000 families out of the 165,000 families receiving relief during December, January and February, 1934-35. The report is published in a pamphlet of 80 pages, entitled "Neighbors in Need". These families lived in thirteen municipalities both city and rural, and may be considered typical of all families on relief.

The report is clear and readable and will be of special interest to physicians on whom falls the burden of giving relief to those who are invalided because of physical sickness or defects.

The following notes were made while reading the report:

One-seventh of the population of New Jersey were on relief in the winter of 1934-35, or 609,000.

Forty-two per cent of all on relief are children, while twenty per cent of the entire population of the State are children.

Three-fourths of relief families are white.

One-fourth of relief families are negro.

One-half of white family heads are foreign born; and three-quarters of them are from south and east Europe; and one-half of them have not become citizens. (Same is true of all foreign born.)

One-quarter of all relief families are negro. (One-half of all families are negro.)

White families on relief:

One-half have native born heads.

One-half have foreign born heads.

Four-fifths of the heads of families on relief are males.

One-fifth are females (50 per cent larger than in the State at large).

Size of families:

One-third of relief families contain five or more members.

	Per Cent
1 in family	13
2 in family	17
3 in family	17
4 in family	16.2
5 in family	12.3
6 in family	9.3
7 in family	6.4
8 in family	3.7
9 in family	2
10 or more	2.8

Family Heads:

	Per Cent
Couples	68.6
Single	5.5
Widowed	14.6
Divorced	0.7
Separated	5.6
Deserted	5.0

Children

Two-thirds of families have children. Number of children—255,000. Considerably more of white families than of negroes have children. One-fifth of heads of families are women.

Health:

One-fourth of family heads are afflicted, and at home with disease.

Two per cent are in institutions (prisons, hospitals, etc.).

Forty-one thousand family heads are afflicted.

Afflictions of family heads:

General (senility, ruptures, diabetes, poisoning, etc.)	18.3
Muscles and bones (rheumatism)	12.7
Injuries	12.3
Heart and circulation	12.1
Respiratory	9.3
Digestive	9.0
Eyes and Ears	8.2
Nervous system	5.0
Uro-genital	5.0
Others	6.4

Education of family heads:

One-eighth none.

One-third less than fifth grade work.

Ages of family heads:

The age distribution of heads of families on relief follows closely that of the whole population. For example, 22.5 per cent of all heads of families on relief are between 25 and 34 years of age; while 21.9 of the heads of all families in the State are in that age group.

Among heads over 50 years, one-fifth of the males and one-half of the females are in poor health.

Seven-eighths of relief families have at least one member in each family able to work.

Families having members available to work:

	Per Cent
None	12.5
1	50.9
2	21.5
3	9.1
4	6.0

Time out of employment:

One-half for three years

Unskilled laborers	3 years
White collar	2½ years
Skilled	2¾ years

Heads available for employment:

Four-fifths of all family heads are available for employment.

Nine-tenths of male heads are available.

Two-thirds of the available heads are unskilled or semi-skilled.

Those that were shiftless before the depression were in only a small proportion. Some had been in the $5,000 a year class.

Heads not available:

In one-fifth of all (37,000) families, the head is not available for employment.

In one-tenth of all (16,000) families, some other member could work.

Most female heads are not available for employment, for they have to stay at home to care for their families.

Health of family heads in the dependent class:

	Per Cent
Not afflicted	38.8
Afflicted at home	56.5
In institutions	4.7

A statistical summary in the appendix (page 71 of the report) is as follows:

STATISTICAL SUMMARY
Winter 1934-35

	State Census	Relief	Relief Per Cent of State Census
Persons	4,041,334	609,000	15.1
Families	985,636	165,000	16.7
Family Heads (%)	100.0	100.0	....
Native White	58.5	39.9	11.4
Foreign White	36.4	33.6	15.4
Negro	4.9	26.5	90.0
Median Family Size	3.47	3.67	+5%
Average Family Size	3.82	4.01	+5%
Children Under 16, Per Cent of Persons	28.9	41.6	14.3
Per Cent of Families with Children Under 16	Not given	63.2	....
Sex of Family Heads (%):			
Male Family Heads	87.4	81.5	15.6
Female Family Heads	12.6	18.5	24.4
Workers (%):			
Families Having No One Available for Work	5.2	12.5	40.2
Families Having One or More Available for Work	94.8	87.5	15.4
Ages of *Male* Family Heads (%):			
Under 45	55.8	55.1	15.4
45 to 64	36.5	37.8	16.1
65 or over	7.6	7.0	14.3

THE WASHINGTON PLAN IN NEWARK

The Medical-Dental Service Bureau, designed and put into successful operation by the Medical and Dental Societies of the District of Columbia, has been investigated and studied by representatives of The Medical Society of New Jersey and the Essex County Medical Society.

Dr. Thomas K. Lewis, Chairman of the Committee on Medical Practice of the State Society, and Dr. LeRoy A. Wilkes, Executive Secretary, visited the headquarters of the Bureau in the City of Washington on April 10, and spent an afternoon consulting its leaders and observing its operation. They have informally expressed their approval of the plan, and will consult the committee before making their formal report.

A committee of the Essex County Medical Society also visited the Bureau in June, and made a report to the Council of the Society. The Council approved the plan and recommended its adoption by the Essex County Medical Society. (See this Journal of September, page 561.)

The Council invited Dr. Arthur C. Christie, one of the organizers of the Bureau, and Dr. Ross Garrett, its Director, to address the Essex County Society at a special meeting which was held on the evening of September 12, and is reported on page 622 of this Journal. The speakers explained the objects of the Bureau and the principles of its operation. An abstract of their addresses appears on pages 576-579 of this Journal.

The question of the adoption of the plan by the Essex County Medical Society will be a special order of business at the regular meeting of the Society to be held on October 10.

The Executive Committee of the Essex County Dental Society is favorably inclined toward adopting the Washington Plan, and is taking steps to inform the members regarding the project.

GOVERNOR HOFFMAN'S CONFERENCE ON SAFETY

A Conference on Safety, called by Hon. Harold G. Hoffman, Governor of New Jersey, was held on September 11 and 12, 1935, in the War Memorial Building, adjoining the capitol grounds, Trenton. The object of the conference was stated on the special announcement as follows:

"New Jersey's annual loss of more than 3000 lives, injury to many thousand others, as well as the economic waste of millions of dollars all resulting from preventable accidents, is too great a price to pay for human carelessness.

"Safety in private and public places can be attained, providing there is sufficient individual demand for and interest in such attainment.

"The Safety Conference called by Governor Hoffman is designed to bring about such interest, as well as the development of adequate preventative measures."

Hon. A. W. Magee, Acting Commissioner of Motor Vehicles, was General Chairman. Two general sessions were held, with an evening banquet that was attended by 500 persons.

The Medical Society of New Jersey sent official representatives to the conference in accordance with its policy to participate as often as possible in conferences and meetings for the protection of lives and health of the citizens of New Jersey.

The conference was divided into four sections:

1. Highway Safety.
2. Industrial and Public Utility Safety.
3. Educational and Recreational Safety.
4. Home Safety and Health.

HEALTH SECTION

The representatives of The Medical Society of New Jersey were especially interested in the Home Safety and Health Section, over which Dr. J. Lynn Mahaffey, Director of the Department of Health of New Jersey, presided. Its program was designed to arouse a popular interest in health and home safety measures. The speakers were as follows:

WEDNESDAY MORNING, SEPTEMBER 11

"Communicable Diseases as Health Hazards"—William H. MacDonald, Chief, Bureau of Local Health Administration, State Department of Health.

"The Facts of the Home Accident Situation"—Julien H. Harvey, Manager, New York Office, National Safety Council.

WEDNESDAY AFTERNOON, SEPTEMBER 11

"Child Hygiene"—Dr. Julius Levy, Consultant, Bureau of Child Hygiene, State Department of Health.

"The Safe Use of Safe Household Equipment"—Katharine A. Fisher, Director, Good Housekeeping Institute, New York City.

"Administration of the Milk Laws"—Dr. James E. Russell, Chairman, Milk Committee, State Department of Health.

"How Home Fires Are Caused"—Leon A. Watson, Expert, Schedule Rating Office of New Jersey.

"The Future Safety and Health of New Jersey's Children"—Dr. Stanley Nichols, Member, State Department of Health, and Chairman of the Committee on Public Health of the Medical Society of New Jersey.

"How the Schools Are Hoping to Promote Home Safety"—Marian Telford, Director, Field Activities and Consultant on Child Safety, Education Division, National Safety Council.

THURSDAY MORNING, SEPTEMBER 12

"Control of Social Diseases"—Dr. A. J. Casselman, Consultant, Bureau of Venereal Disease Control, State Department of Health.

"What the Visiting Nurse Can Do to Promote Home Safety"—Miss H. W. Seifert, Director, Elizabeth Visiting Nurses Association, and President N. J. State Organization for Public Health Nursing.

"Problems in Control of Venereal Diseases"—Carl Daines Bureau of Venereal Disease Control, State Department of Health.

"Lighting for Safety in the Home"—Oscar P. Cleaver, Commercial Engineering Department, Westinghouse Lamp Company.

RESOLUTIONS

Dr. Nichols proposed resolutions on the following subjects, which were adopted by the Section:—

1. Requesting the Legislature to prohibit the use of fireworks, except in public celebrations managed by municipal authority.

2. Requesting the Legislature to supply funds for the compulsory education of school children in safety measures in the home and on the streets.

3. Requesting the Departments of Education and Mental Hygiene to study the effect of radio programs and movies on the mental health of children.

4. Requesting the Mental Hygiene authorities to make constructive plans for educating parents and physical teachers in child guidance in order to prevent maladjustments and the development of institutional cases.

5. Requesting health groups and office holders to continue a vigorous campaign for the prevention of contagious diseases.

EXHIBIT

An exhibit, both commercial and official, was conducted showing charts and safety devices. An interesting exhibit was that of charts of the lowering of infant mortality designed by Dr. Julius Levy, Consultant in Child Hygiene to the State Department of Health.

Another practical demonstration was that of the Aetna Casualty and Insurance Company, showing a device to test the reaction time of an automobile driver in applying his brakes when a traffic light changed from green to red. Visitors were tested and were given a pamphlet which contained the following table:—

THIS IS THE DISTANCE YOUR CAR WILL GO BEFORE IT CAN BE STOPPED, IF YOUR REACTION TIME IS AVERAGE (¾ Second)

Speed of Car	20 m.p.h.	30 m.p.h.	40 m.p.h.	50 m.p.h.	60 m.p.h.	70 m.p.h.	80 m.p.h.
Reaction Dist.	22 ft.	33 ft.	44 ft.	55 ft.	66. ft	77 ft.	88 ft.
Braking Dist.	22 ft.	49½ ft.	88 ft.	137½ ft.	198 ft.	269½ ft.	352 ft.
Total Dist.	44 ft.	82½ ft.	132 ft.	192½ ft.	264 ft.	346½ ft.	440 ft.

The conference was practical in all its phases, and was well designed to arouse public interest in safety precautions.

A. M. A. RADIO BROADCAST

The American Medical Association announces a new radio program beginning on October 1, 1935. It will be broadcast every Tuesday afternoon at 5 o'clock, Eastern Standard Time, from the twenty-eight stations of the Blue Network of the National Broadcasting Company. These stations are: WJZ, WSYR, KDKA, WCKY, WENR, WIBA, KSTP, WEBC, KFYR, KWCR, WREN, KWK, KSO, WBAL, WMAL, WTAR, WPTF, WWNC, WSOC, WIS, WSM, WMC, WJDX, KVOO, WKY, WFAA, KTBS, WOAI.

The broadcast will be on the subject, "Medical Emergencies and How They Are Met". It will be presented in dramatic form, with the doctor as the hero, delivering his services by day and by night in a manner that is both practical and entertaining.

Doctors will do a public health service by telling their patients about the broadcast, and advising them to tune their radios to it at five o'clock on Tuesdays.

THE A. M. A. COUNCIL ON PHYSICAL THERAPY

Every doctor welcomes reliable information regarding the materials which he uses, the drugs and foods which he prescribes, the apparatus which he buys, the institutions which he patronizes, and the character of unknown physicians with whom he may come in contact. The American Medical Association maintains an enormous store of accurate information regarding the professional life of every physician.

The Council on Medical Education and Hospitals has the record and standing of every medical school and of the vast majority of hospitals, either public or private. Its Council on Pharmacy and Chemistry has a reliable estimate of practically every drug which the physician is importuned to use. The Committee on Foods will inform any doctor regarding the composition and nutritive value of many foods and proprietary products, and also will comment on the truthfulness of food advertising.

A recent acquisition to this store of information is a small pamphlet prepared by the Council on Physical Therapy containing a list of the apparatus accepted by the Council prior to May, 1935. The Secretary of the Council writes:

"One of the purposes of the Council on Physical Therapy is to protect the medical profession, and thereby the public, against inefficient and possibly dangerous apparatus, and against misleading and deceptive advertising in connection with the manufacture and sale of devices for physical therapy. Any physician may obtain a copy of this pamphlet (of the Council on Physical Therapy) free by writing to the Secretary, Council on Physical Therapy, American Medical Association, 535 North Dearborn Street, Chicago, Illinois."

The Council also stands ready to help the Medical Societies of the States and Counties to arrange their programs on all phases of the practice of Physical Therapy.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS RECEIVING FREE BIOLOGICALS SINCE JULY 1, 1935

DIPHTHERIA TOXOID

	To Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	31	7	38	12.6
Bergen	68	311	379	126.3
Burlington	41	3	44	14.6
Camden	38	37	75	25.
Cape May	73	19	92	30.6
Cumberland	205	67	272	90.6
Essex	689	271	960	320.
Gloucester	43	26	69	23.
Hudson	2	0	2	.6
Hunterdon	1	0	1	.3
Mercer	8	18	26	8.6
Middlesex	144	23	167	55.6
Monmouth	35	23	58	19.3
Morris	120	56	176	58.6
Ocean	2	3	5	1.6
Passaic	455	140	595	198.3
Salem	14	5	19	6.3
Somerset	60	0	60	20.
Sussex	0	0	0	0.
Union	246	245	491	163.6
Warren	87	8	95	31.6
Totals	2362	1262	3624	1208.

SMALLPOX VACCINE

	To Aug. 31	Month of Sept.	Total to Sept. 30	Average per Month
Atlantic	18	45	63	31.
Bergen	117	99	216	72.
Burlington	62	58	120	40.
Camden	64	103	167	55.6
Cape May	72	28	100	33.3
Cumberland	227	88	315	105.
Essex	493	207	700	233.3
Gloucester	137	111	248	86.6
Hudson	1	0	1	.3
Hunterdon	9	1	10	3.3
Mercer	2	25	27	9.
Middlesex	154	162	316	105.3
Monmouth	4	14	18	6.
Morris	103	283	386	128.6
Ocean	8	5	13	4.3
Passaic	470	447	917	305.6
Salem	32	38	70	23.3
Somerset	94	7	101	33.6
Sussex	0	4	4	1.3
Union	355	660	1015	338.3
Warren	71	136	207	69.
Totals	2493	2521	5014	1671.3

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

OCTOBER

1	Camden
1	Cape May
1	Hudson
8	Bergen
8	Cumberland
9	Mercer
9	Ocean
9	Union
10	Burlington
10	Essex
10	Passaic
10	Somerset
11	Atlantic
11	Salem
15	Warren
16	Middlesex
17	Gloucester
22	Hunterdon
23	Monmouth

NOVEMBER

5	Camden
6	Hudson
8	Atlantic
12	Bergen
13	Mercer
13	Ocean
14	Burlington
14	Essex
14	Passaic
20	Middlesex
21	Gloucester
27	Monmouth
	Sussex

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Englewood Hospital on September 10th. The Bergen County Pharmaceutical Society met with us.

The minutes of the June meeting were approved as printed in the Bulletin of the Society.

The following applications for membership were read:

Junior—

Dr. A. M. Romano, Hillsdale

Associate—

Dr. S. A. Sandler, Hackensack and Jersey City.

The following junior members are to come up for regular membership:

Dr. C. C. Abbate
Dr. G. B. Barlow
Dr. M. E. Branon
Dr. D. John Calabrese
Dr. L. C. Cartnick
Dr. D. C. Clarie
Dr. William G. Gardine
Dr. M. M. Kroll
Dr. N. V. S. Myers
Dr. R. Vilardo

The following communicatinos were mentioned by the Secretary:

A notice from the Essex County Medical Society inviting us to attend their meeting on September 12th, when Dr. A. C. Christie and Dr. Ross P. Garrett will discuss the Washington Plan of credit investigation.

A letter from Dr. LeRoy A. Wilkes stating that the Crippled Children's Commission, headed by Mr. Buch, was coöperating with Dr. B. Franklin Buzby representing The Medical Society of New Jersey; and that Dr. Buzby has set up a Commission consisting of two members of the Crippled Children's Commission, three members of the State Medical Society, and two laymen chosen by the forementioned. This committee will decide on the proper procedure.

A warning from Dr. Howard M. Cooper concerning one Mr. D. S. Schemm who was collecting money from doctors for merchandise from a company which does not exist.

DUES

The President brought up the question of dues. By a vote of 19 to 16, the Society dues were raised from $20.00, as at present, to $25.00 per year.

SCIENTIFIC SESSION

The scientific meeting was in charge of Dr. David Goldberg. The first speaker was Dr. Lloyd K. Riggs, Ph. D., Director of Research and Professor of Biological Sciences, Rutgers University College of Pharmacy, representing the Pharmaceutical Society. He spoke on "The Evaluation of Antiseptics in Modern Practice".

Dr. Albert F. R. Andresen, Long Island College Hospital, was then introduced. He spoke on "Focal Infection", referring particularly to dead teeth, impacted molars, roots and bone particles, tonsils, nose, sinuses, middle ear, and pelvic inflammatory conditions,—cystitis, pyelitis, prostatitis, and proctitis.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held Thursday evening, September 12, 1935, at the Moorestown Field Club, Moorestown, N. J.

E. R. A. COMMITTEE

The Emergency Relief Committee made its report for the fiscal year, stating among other things, that $35,000 had been approved for the physicians of Burlington County during the year just past.

NEW MEMBERS

Dr. Harry P. Landis, Jr., of Palmyra, was elected to membership.

The following applications for membership were read:

William E. Bray, of Pemberton;
John Preston Moore, of Burlington;
John B. Clement, of Beverly;
Louis P. Lapham, of Bordentown.

SCIENTIFIC

Dr. Louis Viteri, Chairman of the Section on Specialities, had prepared a very interesting scientific program.

Dr. Daniel F. Remer, of Mt. Holly, presented an interesting paper on the subject of "Eye Condition Resulting from Intercurrent Diseases". Dr. Remer gave a very practical discussion of those conditions of the eye which result from general infection or toxic conditions.

Dr. Chevalier L. Jackson, of Philadelphia, the next speaker on the program, showed many interesting lantern slides and discussed "Bronchoscopy as an Aid to the General Practitioner". Dr. Jackson mentioned the following indications for bronchoscopy:

1. Foregn bodies, both non-opaque and opaque. Very essential to have x-ray pictures taken at full inspiration and full expiration.

2. New growths.

3. Valuable in the diagnosis and treatment of some cases of tuberculosis. Bronchial obstruction sometimes occurs in tuberculosis, and it may be helpful to the condition.

4. Valuable in the diagnosis and treatment of bronchiectasis. Very few cases can be entirely cured by bronchoscopy, however.

5. Helpful in the care of some asthmatic patients. Useful in the mechanical removal of thick mucus from the bronchi.

6. Post-operative atelectasis due to vicid secretion in the bronchi may be helped very promptly.

7. Bronchoscopy is valuable in the diagnosis and treatment of many cases of pulmonary abscess.

Dr. Jackson also gave a short discussion of "Gastroscopy by use of the flexible gastroscope".

A discussion of Dr. Jackson's paper was opened by Dr. Russell D. Geary, of Riverside.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

MOUNTAINSIDE HOSPITAL

The Medical Board of Mountainside Hospital, Montclair, has decided to extend the privileges of caring for private and semi-private patients in the hospital to the members of the staffs of all other approved hospitals in Essex County.

At a meeting of the Medical Board of Mountainside Hospital, Montclair, held July 23, 1935, the following action was taken:

"*Resolved*: That a letter be sent to the Director of every hospital in Essex County notifying them that the use of our private rooms and semi-private rooms is extended to every physician in this County who is a member of a County Medical Society, and a Consulting or Attending Staff member of a hospital approved by the American Medical Association or the American College of Surgeons."

Levi W. Halsey, M.D., Chairman,
Medical Board.

Fred A. Pringle, M.D., Secretary,
Medical Board.

The *Essex County Medical Society* invited the Essex County Dental Society, members of Boards of Health, hospitals, welfare organization, social workers, and other public spirited groups and individuals to its meeting held Thursday evening, September 12, 1935, at the Academy of Medicine, Newark, to hear Drs. Ross Garrett and Arthur C. Christie speak on "Coördination of Resources for Medical Care". They told how the medical economic problem is being met in Washington, D. C., with the step by step evolution of the "Washington Plan" for coördinating medical, dental, social, fiscal and hospital resources. President John F. Condon presided and introduced the speakers.

Dr. Christie described the development and deficiencies of health insurance plans (see page 576).

Dr. Ross Garrett (p. 577) described the working of the *Medical-Dental Service Bureau* developed by the physicians and dentists in Washington, by which families indigent or with low incomes are cared for without waste of effort or money. The hospitals are spared duplication of social service work; the professions are helped in the problem of financial ability of patients; and the welfare organizations are enabled to appropriate their moneys more economically than ever before. No one needing medical, surgical, or dental care need go without it, and the cost will be adjusted to his capacity to pay. No self-respecting citizen is pauperized; the public meets its obligation in paying for the poor; and the present method of any one choosing his own independent arrangement with his doctor is fully preserved. These benefits for all concerned are achieved by harmonious coördination of the forces already existing, and without intermediate public or private administrative bodies at costly expense.

Dr. James H. Lowrey, Chairman of the Economics Committee of the Essex County Medical Society, reporting for the group that visited Washington, D. C., in June, said (Journal, September, p. 561):

"The Washington Plan has been studied by a committee of The Medical Society of New Jersey and also by the Economic Committee of the Essex County Medical Society, and the County Dental Society. A description of the plan has been published in several medical journals and lay magazines, all with favorable comment.

"Your representatives visited Washington, D. C., and saw the Bureau in operation. We returned completely sold on the plan. To us it appeared to be an ideal plan that is coöperative and non-profiting financially. It is operated by the members of the Medical and Dental Societies, the hospitals, and the Public Welfare Organizations of Washington. Any patient could take his individual problem of medical, dental, or hospital expense and have it worked out for him in an equitable adjustment manner, so that his individual financial problem as well as health problem is solved and cared for.

"The plan coördinates all health facilities, so that indigent, near indigent, and low income patients are cared for. The service is under the control of the professions, and it forestalls tax drains encour-

aged by Federal activity in health relief. As Dr. Garrett stated, 'The Medical Relief should be administered through existing agencies, not through the establishment of additional tax eating units.' It obviates duplication of interviewing and investigating among clinics and social agencies which render service to the indigent and to those of low incomes.

"The Washington Herald in a front page item stated: 'It is the most far-reaching answer yet made by the professions to the increasing demand, as reflected in proposed legislation to socialize health services.' An editorial in the Washington Evening Star stated: 'It will act somewhat in the rôle of financial secretary to the two professions. The professional men will deal with the *disease*. The *business* side of the arrangement will be entirely in the hands of the Service Bureau. The physicians and dentists are preparing to offer some of the practical advantages of state medicine without surrendering the individualistic system in which the great majority of them, and probably the great majority of their patients, believe.'

"Any agency planning medical care for the indigent is preparing to give away medical services which it does not possess, and for which it does not and cannot pay. Until such time as such agencies are in a position to pay for the services of physicians at mutually agreeable rates, the *Medical Profession is entitled to determine the conditions* under which it is willing to furnish medical care to the indigent.

"The only object of the medical society in making this statement is to promote an accord between all the agencies responsible for furnishing medical care to the indigent, and to secure coöperation and understanding rather than friction and discord, in order that no deserving individual in need of care shall go without it. The Washington Plan takes all these and many more points into consideration and offers a solution.

"The committee can find no valid objection to the establishment of a similar plan here in Essex County. Legal advisers inform us that a similar corporation such as the Medical-Dental Service Bureau, could be formed in New Jersey under a similar charter, provided a clause was added in the charter to show that the purpose of the corporation is not to derive any profit for the benefit of the members. This can readily be done.

"The committee feels that, before a Central Admitting Bureau unit and the Board of Public Welfare Permit Bureau is established, a survey should be made of our present facilities for handling all classes of patients.

"The success of this plan depends upon the securing of the most efficient administrative officers and the hearty coöperation and support of the majority of our members."

There was a large attendance at the meeting. Action on the proposed establishment of a similar organization in Essex County was postponed to October 10.

GLOUCESTER COUNTY

Henry V. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held in the Woodbury Country Club on September 19, with eighteen members present, as follows: Drs. M. F. Lummis, I. W. Knight, W. J. Burkett, Pitman; R. K. Hollinshed, Edward Ristine, Westville; Duncan Campbell, H. B. Diverty, Dorothy Rogers, E. E. Downs and Fuller G. Sherman, Woodbury; Samuel Ashcraft, Mullica Hill; C. I. Ulmer, I. M. Gairdner, Gibbstown; Oran A. Wood, Paulsboro; Horace M. Fooder, Williamstown; Dr. H. G. Miller, Cumberland County Society; Dr. Oram Kline, Camden County Society, and Dr. Paul Burkett, Woodbury. Dr. I. W. Knight, Chairman of the Health Committee, presented an interesting report.

A buffet supper was served at the close of the meeting.

SCIENTIFIC

The guest speaker of the evening was Dr. Bernard I. Courve, of the Medical Department of the University of Pennsylvania, whose subject was "Abdominal Pain".

DATE OF ANNUAL MEETING

The Society adopted a resolution changing the constitution to hold the annual meetings in May, instead of November, thus making the current year the same as that of the State Medical Society.

SOCIAL

It was announced that the annual social session of the County Society would be held October 17. This is one of the biggest events of the year.

Drs. W. J. Burkett and M. F. Lummis reported on their visit to the Cumberland County Medical Society.

Drs. Wood, Campbell and Diverty attended the Burlington County Medical Society on September 12.

DEATHS

One of our members, Dr. Wilson Stout, of Wenonah, died suddenly on June 29. Also one of our ex-members, Dr. Cyrus B. Phillips, of Pitman, died suddenly at the age of seventy-eight years.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held Thursday, September 12, 1935, at the Health Center, Paterson, N. J., at nine o'clock, with Dr. MacMillan, President, in the chair.

NEW MEMBERS

The following physicians were unanimously elected to full membership:

Dr. F. Patella
Dr. P. G. Berkhout
Dr. Alfonso Del Mauro

The following physicians were elected to associate membership:

Dr. Philip M. Joffe
Dr. Sidney H. Joffe
Dr. L. E. Thron
Dr. Paul S. Richards
Dr. M. Marion Cohen
Dr Victor F. Desmet

ASSISTANT TO SECRETARY

Dr. James Lomauro made a motion that the Society appoint a lay secretary to assist the Secretary of the Society in the performance of all routine matters; the salary to be not more than $20.00 per month; and that no definite appointment or contract be made as to duration of service. This motion was seconded by Dr. Roemer and unanimously approved.

NOMINATING COMMITTEE

Dr. MacMillan then appointed the following members to serve as a Nominating Committee to report at the annual meeting next month:

Dr. Roemer,
Dr. Ryan,
Dr. Vosberg.

SCIENTIFIC SESSION

Dr. MacMillan then introduced the speaker of the scientific session, Dr. Theodore R. Robie, Consulting Psychiatrist, Orange Memorial Hospital, and Neurologist to the New Jersey State Orthopedic Hospital, Orange, N. J., whose subject was "Birth Control and Selective Sterilization from the Psychiatrist's Viewpoint". The paper was most interesting and was received with great interest. A most stimulating discussion followed with Drs. Marsh, Shapiro, Rothman and others participating.

OBITUARIES

DR. FREDERICK P. WILBUR

Dr. Frederick P. Wilbur, who had practiced medicine in Franklin, Sussex County, since 1908, and was Secretary of the Sussex County Medical Society, died suddenly of heart disease on September 9 at the age of 55.

He was born in Syracuse, N. Y., on October 29, 1879, a son of Dr. Harvey B. Wilbur and the former Emily Petheram. His father for years was superintendent of the State Hospital at Syracuse.

Dr. Wilbur was graduated from Williams College in 1902 and from Johns Hopkins Medical School four years later. He was a member of the medical staff of the Franklin Hospital, the Alexander Linn Hospital of Sussex, N. J., and the Newton (N. J.) Hospital.

Surviving are a widow, Carolyn Laick Wilbur; a daughter, Carolyn Louise, and a brother, H. B. Wilbur, of Seattle.

DR. THEODORE SENSEMAN

Dr. Theodore Senseman, Surgical Director at the Atlantic City Hospital, died there September 9 at the age of sixty. He entered the hospital September 7 at noon, but had been in ill health for a long time.

Dr. Senseman, a native of Atlantic City, was graduated from the University of Pennsylvania Medical School in 1897, and spent the next eighteen months as an interne in Cooper Hospital, Camden, before beginning practice in Atlantic City.

He was a Fellow of the American College of Surgeons and a member of the County and State Societies and American Medical Association. A widow, Mrs. Laura Senseman, survives him.

DR. PHILEMON E. HOMMELL

Dr. Philemon E. Hommell, of 689 Bergen Avenue, Jersey City, died Wednesday, August 21, 1935, after a short illness at seventy-two years of age.

Dr. Hommell was born in Hoboken and received his education in the public schools of that city, and the New York College of Pharmacy. He received his M.D. degree from Bellevue Medical College in 1893. Dr. Hommell was dean emeritus of the New Jersey College of Pharmacy, of which he was one of the founders.

He was a member of the New Jersey Pharmaceutical Society, of which he had been President; The American Druggist Association, Bergen Lodge, No. 47, F. and A. M.; Hudson County Medical Society and the New Jersey State Medical Society.

DECEASED PHYSICIANS

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Carl Mindlin	49	Aug. 20, 1935	McKinley Hosp., Trenton	Haverhill, Mass.	Acute myocarditis. Cerebral hemorrhage. Sarcoma left axilla, lungs and brain.
William J. Condon	56	Aug. 2, 1935	St. Peter's Hosp., New Brunswick	50 Livingston New Brunswick	Cerebral thrombosis.
Philemon E. Hommell	72	Aug. 21, 1935	689 Bergen Ave., Jersey City	Same	Cancer of rectum
Peter J. Zeglio	75	Aug. 3, 1935	112 Somerset St., North Plainfield	Same	Chronic myocarditis. Arterio sclerosis. Cardiac dilatation.
Oliver E. Snodgrass	70	Aug. 27, 1935	317 Ocean Ave., Ocean City	2350 N. 19th St., Phila., Pa.	Chronic parenchymatous nephritis. Arterio sclerosis.
Lefferts Hutton	56	Aug. 14, 1935	12 Marion St., Millburn	Same	Coronary embolism
Eugene R. Hynard	63	Aug. 4, 1935	16 Woodside Rd., Cedar Grove	Same	Arterio sclerosis. Endocarditis.
Edward B. Woodward	64	Aug. 9, 1935	254 Allentown Rd., Yardville	Same	Cirrhosis of liver.

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IT IS WELL RECOGNIZED that the syphilitic patients' chances of complete "cure" are better when an arsenical and a heavy metal preparation are used than when either of these agents is used alone. This is true if the treatment is begun early and continued through 20 doses of the arsenical plus the heavy metal.

For the treatment of syphilis, two products by Squibb are noteworthy—Iodobismitol with Saligenin and Neoarsphenamine. Iodobismitol with Saligenin is a distinctive antisyphilitic bismuth preparation in that it presents bismuth in anionic (electro-negative) form. It is a propylene glycol solution containing 6% sodium iodobismuthite, 12% sodium iodide and 4% saligenin.

Clinical trials and experiments have shown that Iodobismitol with Saligenin is rapidly and completely absorbed and slowly excreted, thus providing a relatively prolonged bismuth effect. Repeated injections are well tolerated. Its content of 4% saligenin—a local anesthetic—is an additional advantage. Indicative of its efficacy is the fact that Iodobismitol with Saligenin has been shown in early syphilis to produce rapid healing of the primary lesion. In late syphilis its action is very satisfactory.

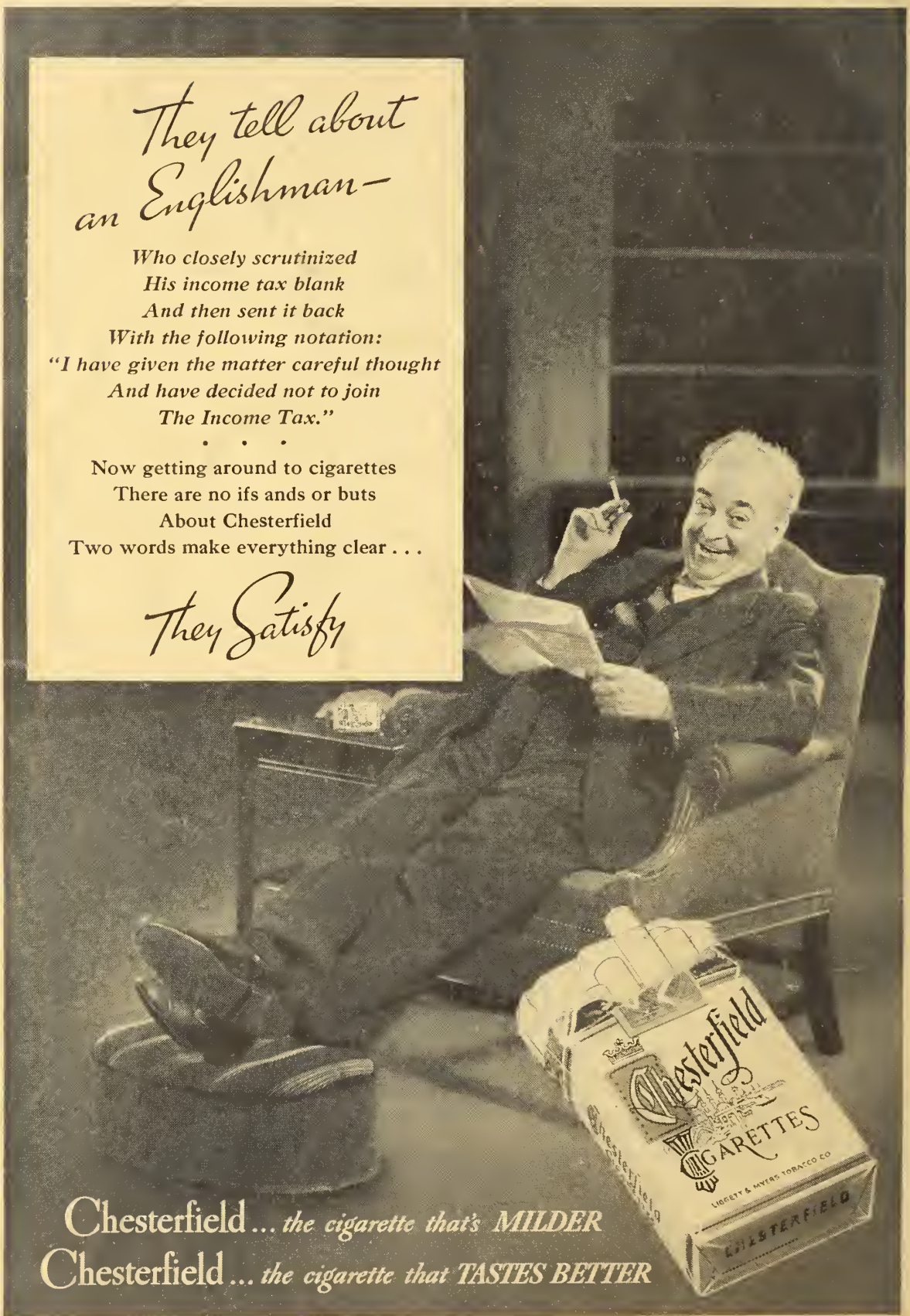
Neoarsphenamine Squibb is preferred as an arsenical because it is readily and rapidly soluble; it can be easily administered; and it possesses uniformly high spirocheticidal power and low toxicity. Other Squibb arsenicals are Arsphenamine and Sulpharsphenamine.

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ANNUAL MEETING, JUNE 2-4, 1936, IN HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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Chloroform (approximately)	3 Min.
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You gave him Tetanus Gas-Gangrene Antitoxin because you knew that his wounds very likely harbored the dreaded anaerobic organisms—tetanus, perfringens, vibrion septique. You knew that he, like all your patients with contaminated wounds, was a potential victim of tetanus or gas-gangrene.

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The physician desires no compromise with safety. Protection against these three potential factors in anaerobic infections is afforded by Tetanus Gas-Gangrene Antitoxin (Combined), Refined and Concentrated, P. D. & Co.



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OF
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Editor of
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Executive Officer—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

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EDITORIALS

Legislators as Guests of the County Society

Instructing law-makers in regard to medical bills is one of the major functions of a County Medical Society. Legislators sometimes complain that doctors seldom go out of their way to advise them except to ask favors. But the majority of legislators are naturally in favor of the point of view of the doctors and will aid them if the medical profession makes the proper approach.

A legislator belongs to the group of public health workers, for it is he who decides what form the official health organization shall take, and each year he supplies the funds for its support. The legislator and the physician meet on the common ground of medical service—the doctor in one branch, and the legislator in another—for each performs an essential duty for the benefit of the community. The legislator welcomes the advice of his more experienced colleague, provided it is given to him as a brother worker.

The best approach to the legislator is through the County Medical Society, where he meets the doctor on a common ground of sociability, and each learns from the other. The legislator can instruct the physician in the intricacies of passing laws and the methods of securing support, while the doctor can describe human needs that are hidden from non-medical eyes.

The initiative for meeting the legislator belongs to the officers of the County Society who invite him to a social meeting, preferably a supper. The opportunity will be the more effective if a few political leaders are included.

The program of the supper meeting will begin with seating each legislator between two doctors who are assigned to the particular service of entertaining their guest with tact and diplomacy according to his individual tastes and preferences. Congeniality is the basis of the influence which the doctors will have upon their guests.

The formal program will come *after* the supper while the guests are in a receptive mood. It will consist of very brief talks on community health projects given by two or three members who are known to be leaders in medical movements. The program will close with a response from one or two of the guests.

The entertainment of the legislators by every County Society during November or December will prepare the way for mutual understandings during the winter session of the Legislature.

The Executive Officer

This Journal of October, page 616, contained the announcement of the Board of Trustees that the title of the *Executive Secretary* had been changed to *Executive Officer,* following the re-assignment of his duties. This action had become necessary because of the gratifying increase of the efficiency of the State Society, and the frequently expressed desire of the leaders of the County Societies for advice and assistance in harmonizing their activities with those of the State Society. This objective is expressed in paragraph four of his assignment, which reads:

"In the Executive Offices and in the field he (the Executive Officer) shall integrate the activities of the officers and the Committee members in the State and County Societies."

The work of the Executive Officer has been along two lines:

1. Secretarial.
2. Advisory in medical organization, public health and economic fields.

The purely secretarial duties of the Executive Offices have been systematized and organized by the Executive Officer to such an extent that the Executive Offices now contain a complete file of records of all lines of activity of the State Society, ready for instant reference. This work can now be carried on by his non-medical assistants with his oversight. Since he is relieved of these routine duties, the Executive Officer can devote a far larger proportion of his time to the advisory duties expressed in the second paragraph of his instructions, which reads:

"In conformity with the declared policy of the Society that the affairs of the Society shall revolve around the President during his term of office, the Executive Officer shall be his *chief aide* in carrying into effect his policies."

This assignment is not an innovation, but is a recognition of the field work that the Executive Officer has always been doing to the satisfaction of the officers and committeemen of both the State and County Societies. His experience as a medical practitioner and executive insures him a welcome as a much needed adviser who, as the chief aide of the President, is free to instruct and inspire the officers and committeemen, so that the ideals of Medical Society responsibility and leadership may be realized. The need of expanding and unifying the contacts by the officers and committeemen is evident when one realizes that one thousand members of the State Society now serve as officers and committeemen of The Medical Society of New Jersey and its twenty-one Component County Societies.

This broadening of the field of activity of the Executive Officer is a recognition of the importance of the County Societies, whose members not only carry out the policies of the State Society, but often originate local activities which are examples for other societies to emulate. In fact, the officers and committeemen of the State Society are usually chosen because of their record for leadership in their *County Societies.* The responsibility of *delivering* all the forms of medical service that are demanded under modern conditions devolves upon the army of local practitioners of medicine whose immediate contacts with their fellows are made in their County Societies. It is to extend their contacts to include those with the State leaders that the new assignment is made to the Executive Officer.

The New Jersey Tuberculosis League

In accordance with the policy of The Medical Society of New Jersey to maintain close contacts with all groups engaged in public health work, the meeting of the New Jersey Tuberculosis League on October 25 is reported on page 665. The League is promoting a campaign for the discovery of early cases of tuberculosis among school children through mass examination by means of the tuberculin test, followed by x-raying the reactors. Several of the speakers touched upon the practical results to be expected from the mass examinations, emphasizing the research value of the examinations as an indicator of the

prevalence of tuberculosis in children to be used as a basis for future action. Physicians recognize the value of a determination of the case incidence, although they await the reports of the testing.

The field of the plan for the mass testing of school children would seem to be those localities in which funds are voluntarily contributed for the purpose of making the tests. If a certain amount of money is appropriated by a community for the eradication of tuberculosis, physicians believe that it should be spent on individual cases that can be detected by the examination of children who have been in contact with known cases, especially those children who show the evident clinical signs which are associated with tuberculosis.

Physicians also recognize the desirability that the children who are examined in clinics should be those which are referred by their family doctors; and also that all reports should be sent to the family doctors and not given directly to the parents.

The policy of The Medical Society of New Jersey is that a lay organization should consult the County Medical Society before instituting a mass action along any public health line. The adoption of this policy will promote an understanding between the Lay Health Groups and the Medical Profession.

Developing a Service

A characteristic of The Medical Society of New Jersey is that it "follows-through" whatever it undertakes.

Every successful action of any group of persons is the outcome of planned steps which follow one another in logical sequence, beginning with a *general statement of a principle,* and ending in *specific action* by the individuals of the group. The outstanding efficiency of The Medical Society of New Jersey is the result of its orderly performance of each step that is necessary for the development of an *ideal* into an *active service.*

A service by The Medical Society of New Jersey is developed in five stages:

1. An *objective* is stated.
2. A *policy* is outlined.
3. A *project* is planned.
4. An *enterprise* is undertaken.
5. The *service* is delivered.

1. AN OBJECTIVE STATED BY THE HOUSE OF DELEGATES

Every new service begins as an *ideal* which is shared by thoughtful members and is stated by the President or other officer in his annual report. The "Transactions" of the annual meetings abound in essays on ideals whose realization seems impractical when they are first propounded. But there comes a time when an ideal is proposed as a specific objective, and is adopted by the House of Delegates.

An example of an objective stated is that proposed by the Chairman of the Public Health Committee and adopted by the House of Delegates in 1933, that physicians should assume the leadership and responsibility for the general health of the citizens of New Jersey. (Transactions 1933, page 28.)

2. A POLICY OUTLINED BY THE TRUSTEES OR WELFARE COMMITTEE

After an objective has been stated, the policy or general action to be taken is outlined by the Trustees or the Welfare Committee.

An example of a policy outlined is that of the Welfare Committee through its sub-committee on Public Health that general health should be protected by immunizations against diphtheria and smallpox, which should be given by physicians in their private offices, instead of in public clinics. (Journal, May, 1934, page 287, and Transactions, page 11.)

3. A PROJECT PLANNED BY A COMMITTEE

The next step in the realization of an objective is that the general policy shall be made a definite *project* to be carried on in accordance with a specific plan made by a committee assigned to that duty.

The policy that immunizations should be done by physicians in their private offices became a definite project when the Public Health Committee made plans for carrying on the

Public Health Hour. (Journal, May, 1934, page 287.)

4. AN ENTERPRISE UNDERTAKEN BY THE COUNTY SOCIETIES

When the method of carrying out a project has been planned, the committee that has it in charge must persuade every County Society to adopt it as an *enterprise* to be promoted by a local Public Health Committee similar to that of the State Society.

A Public Health Committee in nearly every County Society has been actively promoting the Public Health Hour as a local enterprise. Reports of the activities of County Societies in regard to the Hour have appeared in nearly every issue of The Journal during the past year.

5. THE SERVICE DELIVERED BY MEMBERS

The final test of the success of a project or enterprise of a medical society is the record of the actual *delivery of service* by the individual members. An enterprise is successful when the members take an active part in it.

Every issue of The Journal contains a table showing the number of immunizations given in the enterprise of the Public Health Hour.

FOLLOWING-THROUGH

The "following-through" system of The Medical Society of New Jersey needs strengthening, especially in its final stage,—that of making contact with the members, and advising them in their local activities. The attitude of an individual member of the State Society depends largely on that of his County Society. The State Society is extending its system of *written communications* by adding *personal contacts* of the State officers and staff with the members of the County Societies, and so promoting mutual understandings and appreciations of opportunities and responsibilities.

The Annual Assessments

Secretary Morrison has sent a notice to the Secretary of each County Medical Society reminding him that the assessment of the State Society is now due in accordance with the By-Laws, Chapter IX, Section 2, paragraph (a), which reads as follows:

(a) *Annual Assessment of Members.* On the first day of January in each year there shall be levied on each component society a *per capita* assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of the Medical Society of New Jersey not less than five days before the first of February, together with a list of the members for whom such payment is made. A similar *per capita* assessment shall be paid in the same manner immediately upon the admission or reinstatement of any such member, except that for a new member admitted after October first of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the Journal.

The payment of dues is necessary in order that the name of a member shall be included in the "Official List" that is published annually, in accordance with the By-Laws, Chapter I, Section 2, paragraph (a), which reads as follows:

(a) February first in each year is the final date for closing the official list of members. Five days before this date the treasurer of each component society shall forward to the secretary and to the treasurer of this society a complete list of all paid-up members, with their correct addresses. After this date no name shall be accepted for the official list.

It is to the interest of every member that he pays his dues promptly on receiving a bill from his County Treasurer.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey

It has been suggested that the President of the *Society for the Relief of Widows and Orphans of Medical Men of New Jersey* write an editorial, and again explain the present status of this institution fraught with so much service for fifty-three years. The Society was incorporated under the Laws of the State of New Jersey on May 20, 1882. The first thought in its creation was when early in 1881 we made a collection to decently bury a good colleague. The late Drs. Joseph Osborne, Charles J. Kipp, and the writer talked the matter over during the State Society Meeting in that year. Gradually, we worked out a plan which could not fail under ordinary conditions, and which was bound to relieve much distress.

Now and then an addition was made to the by-laws as the Society saw fit. However, in the main, we worked on the old principle all these years. Dr. Osborne was its first President. On his demise, Dr. Kipp was elected, and since his death the writer has acted in that capacity.

We have had but two Treasurers, the late Dr. Kent and at present Dr. H. A. Tarbell.

Drs. William Rankin, Jr., Archibald Mercer and Charles D. Bennett were Secretaries until the time of their death.

This is not a life insurance nor an assessment insurance. The Society has been organized to give the widows and orphans of its members an early and immediate help when they most need it. The writer is sure that in this respect we have attained a great success. Not only have we been able to do that, but have also been able to help members along during long illnesses, when they were unable to keep up their indebtedness to the Society, by assisting them to remain in good standing.

The membership consists of any member of the profession in good standing in the State of New Jersey, and elected by the Trustees under the by-laws of the Society. There are thirteen members of the Board of Trustees including the President, Vice-President, Secretary and the Treasurer. The writer has always been proud of the high ethical attainments of our Board of Trustees. There are three custodians of the "Permanent Fund", one of which is to be from the Society at large, one from the Board of Trustees, and the Vice-President. All bills and benefits can be paid only by order of the "Standing Committee" and the President.

A regulation in the by-laws directs how the members may be elected. The name of the candidate, recommended by two Fellows, is reported to the "Standing Committee", which passes on the vouchers, and presents the name or names to the Board of Trustees.

There is an initiation fee of two dollars, and a first assessment of one dollar. This first one dollar assessment is for those under fifty years of age. For those between the ages of fifty and sixty, there is an assessment of two dollars, and after sixty it is three dollars. As soon as a member's death is announced, an assessment is collected, and seventy-five per cent is immediately paid to the widow, orphan, or his heirs, as appointed by the deceased member. In fact, we are always one assessment ahead. Many requests have come from widows whose husbands have not been members. We regretted exceedingly that we could not help them out. Twenty-five per cent of the assessment is added to the Permanent Fund. This permanent fund is our stronghold, and now amounts to $56,266.44. It is due to the careful investments in this permanent found that the Society has passed through several depressed times. Our investments are as follows, and are controlled by the law which permits Savings Bank investments:

U. S. Treasury 4's—1944-1954 Bonds	$ 7,000.00
First Mortgage Certificates, Guaranteed (5½%)	36,000.00
Hudson Co. Park Bonds (4½%)	2,000.00
West Jersey and Seashore R. R. Bonds (3½%)	1,000.00
City of East Orange Playground Bonds (4's)	1,000.00
Town of Montclair School Bond (4's)	250.00
On deposit in Franklin Savings Bank	4,738.94
On deposit in Fidelity Union Bank	2,455.91
On deposit in Howard Savings Bank	1,821.59
	$56,266.44

Members in arrears for a certain length of time must be dropped from the roll, but only then when two-thirds of the Board so vote.

The officials looking after the funds of the Society are under bond. The custodians of the permanent fund at the present time are Dr. R. N. Connelly, Dr. E. S. Sherman and Dr. Hugh M. Hart.

The Treasurer deposits all moneys coming in to him. This is called the "Contingent Fund", and is deposited in such banks as the Board of Trustees elect. Dr. H. A. Tarbell has been Treasurer for some years to our entire satisfaction. All of his checks are countersigned by the President. These funds are used to pay for the current expenses. Any surplus in this fund may, at the discretion of the Board of Trustees, be transferred to the Permanent Fund. From this fund nothing can be withdrawn. The proceeds of the permanent fund, however, can be donated to needy widows and orphans. This has been done since the fund amounted to ten thousand dollars.

The Board of Trustees are always delighted to give needy widows of deceased members such donations as they think will help them out. Again and again they have requested information from members which would suggest what help should be given.

Any amount not so donated is returned to the permanent fund at the discretion of the Board of Trustees.

Benefactors have left us by will, or usually more often through their widows, their amount of money coming to them. This money has always been added to the permanent fund. The Annual Report will give you the names of such benefactors.

The writer has laid before the reader in as short and concise a way as possible the work of the Society.

We have learned that the true object of the Society is not understood by many physicians. We regret this exceedingly for on various occasions the writer has sent special announcements to all members of The Medical Society of New Jersey. This is not an Essex County affair. It should interest all doctors in the State. It is true that most members come from this county, with Union and Hudson Counties also having a large membership. But then, the profession in these counties has experienced the great benefit shown. I am sorry to report that three counties report no members.

Another criticism is that it will fail as all assessment insurance has failed. This is not an *assessment insurance* in the ordinary sense of term as I have already noted above. We pay no salaries except for clerk hire.

Because twenty-five per cent of the assessments goes to the permanent fund, it can for this reason not fail so far as human foresight goes. The writer of this has interrogated financial men who look at our Society as a safe institution. This is the only institution of its kind in the country. The writer has learned, however, that some States are studying the matter with interest.

We learn that the young physician is not interested. He will be when he is asked to contribute to the relief of his friend's widow. The writer wonders how much real charity he is displaying in such a matter. We are always delighted when a young doctor asks to become a member.

During these fifty-three years, we have paid assessments to the heirs of deceased members to an average of six and a half per year. In 1934 we paid to families of twelve members, all of whom died of cardiac diseases. Several years ago, we paid to the families of twelve members, four of whom died of cancer, and eight of cardiovascular disease. Twelve is about the usual number at this time.

Let the writer say again that this is not a life insurance, but a desire to help the families of those of our profession who need it. In the years to come, this help will increase as the income of the permanent fund increases.

The members of the Board of Trustees feel they have been under great obligations to the Woman's Auxiliary. Doctors' wives should be vitally interested. It would give the writer pleasure to send our last annual report to those who would care to study it.

The writer, or the Secretary, Dr. William D. Miningham, will be exceedingly delighted to answer questions or give explanations regarding the Society and its work.

Edward J. Ill.

ORIGINAL ARTICLES

Symposium on Primary Carcinoma of the Lung

ROENTGEN DIAGNOSIS OF PRIMARY CARCINOMA OF THE LUNG

By William Klein, M.D., New Brunswick, N. J.

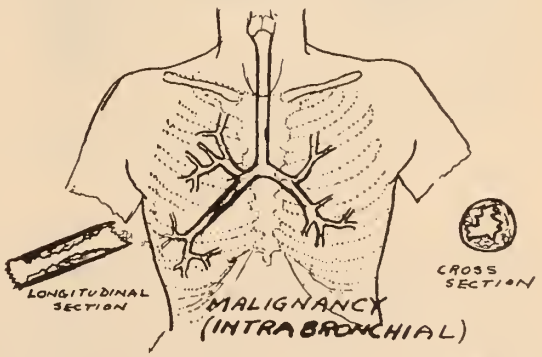
Read before the Section on Radiology, at the 169th Annual Meeting of The Medical Society of New Jersey, on May 2, 1935, in Atlantic City, in a Symposium on Pulmonary Carcinoma of the Lung

In presenting the subject of primary carcinoma of the lung, I shall limit myself to the meaning of the word and exclude every other pathological condition that may exist within the pulmonary system. It is worthy of note that primary carcinoma of the lung was only very recently removed from the realm of the infrequent and unusual. Up to a decade ago only about one per cent of the carcinomata which ravaged the human body was found in the lung. Within the last ten years, however, the percentage has increased to that of five per cent and in some places ten per cent, which is equal to the frequency of malignancies present within the stomach, colon, etc. Even at the autopsy table the condition was frequently overlooked by the pathologist. The reason for this was that the complications have so overshadowed the primary underlying pathology that even the pathologist would not think of looking for a primary lesion, which may be so minute as to be overlooked, except by a very keen observer. Whether this increase is due to the fact that we are better diagnosticians, or whether it be due to the fact that the disease has really increased in recent years, is a question. I am, however, inclined to believe that it is due to the fact that we *are* better diagnosticians, and that we are more primary-carcinoma-lung-minded.

In classifying primary carcinoma of the lung, I would like to limit myself to the usual three classifications, viz.: (1) Endo or intra bronchial; (2) the submucosal or peribronchial, both of which are spoken of as bronchogenic types of malignancy; (3) the parenchymal type, occasionally spoken of as the alveolar type.

Though any of these types may give rise to almost any type of complications, yet to a certain degree each and every one of these types results in certain definite clinical bronchoscopic and radiographic manifestations, and for this reason I would like to make a plea that the clinician, bronchoscopist, and even the pathologist coöperate with the roentgenologist in an attempt to make these diagnoses. Without the help of one another, we shall go back to the 1 per cent of carcinomata being present within the lung as found up to a decade ago.

In speaking of the *endobronchial* type of malignancy, one of the most characteristic signs from the clinician's viewpoint is that the patient will complain of a long continued cough; a cough which cannot be controlled by

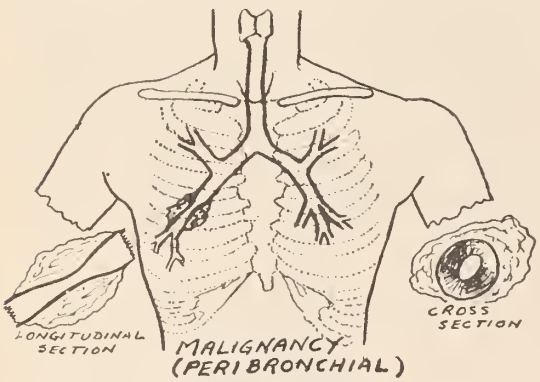


Diagramatic Drawing of Intra-bronchial Malignancy—Bronchoscopic Appearance

any kind of medication; a great loss of weight and strength. The patient may develop symptoms of bronchial asthma and one of the most pathognomonic symptoms. He may notice bloody expectoration. The reason for these findings are that an endobronchial carcinoma is an ulcerating disease and because of its ulceration it is an irritating condition, and because of this the symptoms above described will be present. If the roentgenologist now gets the case, he will usually find that the individual has already developed certain con-

ditions, the most predominating of which is suppuration within the lung, due to either complete or partial block by the new growth, which results in an atelectatic condition, poor ventilation, breaking down and abscess formation. If now the roentgenologist is primary-carcinoma-lung-minded, he will call upon the bronchoscopist to confirm the suspicion that he has of the presence of a primary intrabronchial malignancy. The bronchoscopist will generally find a bleeding, ulcerating lesion within the bronchus, unless it is so close to the periphery that it cannot be seen with the bronchoscope.

In speaking of the *submucosal* or *peribronchial* type of carcinoma of the lung, I should like to emphasize the fact that since

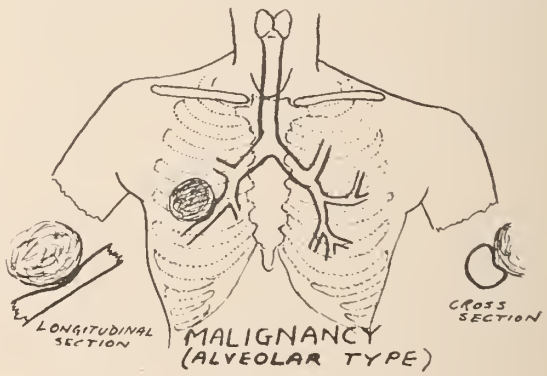


Diagramatic Drawing of Sub-mucosal Malignancy—Bronchoscopic Appearance

the condition here spreads along the lymphatics much more readily than the endobronchial type, that more complications may be present than in the first type, but again if the roentgenologist is primary-carcinoma-lung-minded and bears in mind the complications characteristic of each type of malignancy, he should have no trouble in making the correct diagnosis because of this lymphatic spread. These patients very frequently develop fluid in the pleural cavity, or in the pericardial sack, or they may extend along the lymphatics and result in the enlargement of the lymph nodes within the mediastinum and by their size cause compression of any of the important structures within the thorax, such as the pulmonary arteries, veins, superior vena cava, or even the inferior vena cava, and these in turn give symptoms characteristic of such involvement.

One such case we had here. The patient was brought in and a diagnosis of fluid in the pleural cavity was made. There was a suspicion of submucosal type of malignancy; the fluid was aspirated. The symptoms comprised of edema of the face and conjunctiva, with cyanosis of the face. These findings were confirmed at a post mortem study. Frequently, when the pericardium is involved, the patient may complain of nothing more than precordial pain, and it is only after a careful follow-up study that submucosal type of malignancy is found, explaining the basis for pain—now called pseudo-anginal carcinosis.

Cases are on record where the malignancy has extended along the superior vena cava into the right auricle, resulting in what is known as ball thrombosis of the right auricle, which gives definite clinical findings as characterized by whiteness of the tip of the nose, ears, finger tips, toes, etc. This finding alone, if one is primary-carcinoma-lung-minded, should put one on guard to the type and location of the malignancy that may be present in the individual, although malignancy in other regions may result in similar conditions. If the bron-



Diagramatic Drawing of Parenchymal Type of Malignancy—Bronchoscopic Appearance

choscopist examines such a patient, he will find nothing more than a narrowing of the lumen without any ulceration. Clinically, the patient will not cough early; because of there being no ulceration there is no irritation and consequently no cough. This patient may go on with practically no symptoms except for a possible loss of weight, some dyspnea due to fluid in the pleural cavity or pain in the peri-

cardial sack, or symptoms due to any complications that he may develop.

In the third or *parenchymal type* of malignancy the infiltration generally starts within the small alveoli and gradually extend and involve the parenchyma, giving practically no symptoms except loss of weight and weakness. It is frequently diagnosed only when the patient is sent in for x-ray for some other condition, and the fact that he is running a temperature, at which time one will again note if one is primary-carcinoma-lung-minded, that a mass exists, that a breaking down and abscess formation has resulted within the center of this mass clinches the diagnosis. Bronchoscopy of this individual will show nothing within the bronchus except that there may be a narrowing of same due to compression and that there is a fixity and rigidity as sensed by the bronchoscopist who is acquainted with this condition. It is in these types of malignancies that some hope of a cure may be had since a lobectomy or even pneumonectomy may be done.

I shall now present three cases, each characterizing one of the three types described—out of a series of ten checked by post mortem findings:

Case 1

T. K., male, aged 56, admitted 9/29/34; died 10/4/34.

History, present illness: Pain in chest with two growths on either side of chest. Onset February, 1934, with pain in chest followed by the two growths two weeks later—one anterior left chest and one right lateral wall of chest. Growths gradually increased in size. Excessive cough with hemoptyses at admission which progressed from minor complaint at onset. Great loss of weight, marked weakness, excessive and drenching sweats, mild dyspnea, anorexia.

Past History: Fair health.

Operations: Removal of left kidney twelve years previous—pathology not known.

Occupation: Handyman.

Physical Examination: Positive signs—Fetid breath. Anterior and posterior cervical chain adenopathy. Thorax emaciated—globular mass, hard, movable present in region of left nipple. Another hard fixed immovable mass (size of orange) in right axilla; both masses tender.

Lungs: Expansion limited and difficult.

Progress Notes: Flat throughout entire left side. Anterior and posterior and axilla. B. S. distant and bronchial in character.

Extremities: Clubbing of finger tips.

Clinical Diagnosis: Carcinoma of left lung with metastasis and extension.

Mass in left chest removed 10/3/34. Pathology report: Transitional cell carcinoma.

Clinical Course: Rapidly downward. Excessive cough with feted sputum expectoration.

X-Ray Finding: Intrabronchial carcinoma left lower lobe bronchus with lung abscess due to obstruction of bronchus.

Bronchoscopy was not done due to condition of patient.

Wassermann: Positive.

Kahn: Positive.

Urinalysis: Negative.

P. M.: Primary carcinoma of left lower lobe bronchus with partial obstruction of lumen.

Extensive confluent suppurative necrotic bronchopneumonia of left upper and left lower lobes with bronchiectasis. Spillover terminal bronchopneumonia of right lung. Degeneration of myocardium. Subacute infectious splenic swelling. Fibrous perisplenitis (limited autopsy).



Case 1 Case 2

Case No. 1.—Endobronchial Malignancy, Left Lower Lobe, with Metastases to Thoracic Cage in the Right Side.

Case No. 2.—Submucosal Malignancy with Fluid in Pleural Cavity and Compression of Right Superior Mediastinal Contents.

Case 2

W. W., male, aged 58, admitted 7/15/34; died 7/17/34.

History, Present Illness: Admitted complaining of frequent dry cough, pain in right chest, and dyspnea. This he attributed to having drunk poison alcohol. Onset was gradual three weeks previous.

Past History: Denied previous illness. Heavy smoker and drinker.

Physical Examination: Well developed and well nourished; face flushed and somewhat swollen; dyspneic and orthopneic.

Lungs: Expansion equal, percussion note, dullness over right middle lobe, as well as diminished breath sounds; some dry râles in both lungs; blood pressure 120 over 72.

Extremities: Clubbing of finger tips.

Clinical Diagnosis: Pleurisy; alcoholism.

Clinical Course: Rapidly downward.

X-Ray Finding: Complete obliteration of the right pulmonic field with displacement of heart to the left, appearance is that of pleural effusion on right.

X-ray after chest tap, area of density still present in region of upper two-thirds of right lung field

with displacement of heart and mediastinal structures to the left. Diagnosis—Free fluid in pleural cavity—mediastinal tumor with compression of mediastinal structures, secondary to **submucosal** carcinoma.

Bronchoscopy: Was not done due to patient's condition.

Urinalysis: Albumen trace.

Chest Fluid: Specific gravity 1.017. Culture negative, no acid fast bacilli found.

Wassermann and Kahn not done.

P. M. Diagnosis: Primary carcinoma of right upper lobe bronchus with stenosis. Carcinomatous infiltration of peribronchial and interlobular interstitial tissues of right upper lobe with compression of branches of pulmonary vein to right upper lobe.

Localized marked congestion, hemorrhage, and edema of parts of right upper lobe.



Case 3 Case 4

Case 3.—X-Ray Print.

Case 4.—X-Ray of a Case of Carcinoma Involving a Circumscribed Area of the Left Upper Lobe.

Carcinomatous infiltration and metastases to tracheo-bronchial and mediastinal lymph nodes and interstitial tissues.

Marked narrowing of superior vena cava, with edema of soft tissues of head, neck and upper extremities.

Compression of right pulmonary artery and vein trunks, esophagus, azygos vein.

Edema of vocal cords.

Encapsulated right hydrothorax.

Pericardial effusion.

Dilatation and hypertrophy of right auricle and ventricle.

Multiple isolated metastases to both lungs, liver, stomach, and sigmoid colon, and cervical lymph nodes.

Patchy marked congestion of spleen.

Arteriosclerotic scars of kidneys.

Congestion of G.-I. tract.

Case 3

S. H., male, aged 51, admitted 4/19/35; died 4/29/35.

History, Present Illness: Twelve weeks previous he "caught cold"; began to cough and felt much pain in the left chest with soreness in both extremities. Sputum white, no bleeding, but felt progressively worse. Had artificial pneumothorax three weeks previous.

Past History: Had frequent colds and sore throats; occasional night sweats. Dyspneic at times at night, fatigues easily, slight afternoon temperature; no chills. Hot, swollen, painful knee and ankle joints, also in left upper extremity and shoulder since onset.

Occupation: Janitor.

Physical Examination: Undernourished, pale, and dyspneic. Occasional cough without sputum. Some cyanosis of the neck. Eyes, internal strabismus, blue sclerae. Mucous membrane of lips pale, tongue moist, teeth poor.

Lungs: Expansion equal; prolonged expiration on left side. Bluish pigmentation of the skin to the left of the sternal border. Dullness at left apex to the sternum and as low as the fifth rib anteriorly; tympanic note at left base and axilla. Decreased fremitus over entire left chest, also diminished breath sounds. Sibilant râles at both bases.

Heart: Sounds of poor quality; no murmurs; left border cannot be defined. Blood pressure 145 over 75.

Abdomen: Bulging and dullness in the flanks; distention; tenderness over entire abdomen, especially upper quadrant. Inguinal glands on right side enlarged and tender.

Extremities: Stiffness, tenderness of all joints of left upper extremities, including shoulder. Other joints negative. Marked *clubbing* of fingers and toes.

Clinical Diagnosis: Carcinoma of the left lung (upper lobe). Chronic myocarditis with passive congestion.

Artificial pneumothorax of left chest.

Clinical Course: Complaint of weakness and pain in chest. Bronchoscopy recommended; but not done due to patient's condition. Temp. 99-101.4°.

X-Ray Finding: Evidence of exudative infiltration involving left upper lobe, mainly near periphery, with some production centrally and extending toward the hilus. Because of age of patient and clinical history, the possibility of parenchymal type of malignancy should be borne in mind.

Urinalysis: Albumen 2 plus. Microscopic: Few granular casts, occasional RBC and WBC.

Wassermann: Negative.

P. M. Diagnosis: Primary carcinoma of left upper lobe with invasion of chest wall and metastases to regional lymph nodes. Subacute bacterial endocarditis of mitral valve. Old and recent anemic infarcts of kidneys. Severe anemia. Clubbing of fingers. Thrombophlebitis of inferior vena cava and both common iliac veins.

Pulmonary embolism right upper lobe.

Hypertrophy of prostate.

PRIMARY CARCINOMA OF THE LUNG—PERORAL ENDOSCOPIC STUDY

By Henry Boylan Orton, M.D., Newark, N. J.

An address delivered before the Section on Radiology at the Annual Meeting of The Medical Society of New Jersey in a Symposium on Primary Carcinoma of the Lung, on May 2, 1935, in Atlantic City

This contribution to the symposium on primary carcinoma of the lung from a peroral endoscopic viewpoint is based on cases taken from my records, of which I am reporting twenty-one.

Unproductive cough is a positive indication for bronchoscopy, as stated by Drs. Chevalier Jackson, Ballon, Clerf, Miller, Vinson and others; and it is almost a routine procedure in the study of cough with expectoration or hemoptysis.

Case 1

7130-0; M. C., male, aged 55 years, clerk. Unproductive cough since 1918. Pain in left chest with hemoptysis and dyspnea. Lymph-nodes in neck palpable with dilated veins.

X-ray: Consolidation on the left side.

Bronchoscopy June 6, 1930: In the left bronchus at the level of the upper lobe, a mass completely filling the bronchus, causing atelectasis of area beyond. (Picture No. 1.)

Biopsy: Squamous carcinoma, Grade II.

Case 2

W. F., male, aged 42 years; Fitkin Memorial Hospital, May 18, 1932. Pain in left chest with cough, hemoptysis, loss of weight, and dyspnea.

X-ray: Consolidation left chest.

Bronchoscopy May 18, 1932: In the left bronchus below the upper lobe bronchus, a mass occluding the bronchus. (Picture No. 2.)

Biopsy: Carcinoma, Grade II. Deceased August 5, 1932.

Case 3

8354-0; P. G., male, aged 49 years, railroad worker. Had a cough for one year with pain in left chest and hemoptysis; loss of weight and dyspnea.

X-ray: Abscess, left side.

Bronchoscopy May 28, 1932: Left bronchus below the upper lobe bronchus stenosed with granulations, causing retention of infected material. (Picture No. 3.)

Biopsy: Epidermoid carcinoma, Grade IV.

Case 4

5414-0; T. H., male, real estate broker. Complained of pain in back, cough and hemoptysis, with loss of weight.

X-ray: Consolidation on the right side.

Bronchoscopy May 7, 1928: Below the middle lobe bronchus on the right side, a mass, bleeding readily on contact with bronchoscope. (Picture No. 4.)

Biopsy: Papillary carcinoma.

Case 5

8701-0; M. K., aged 56 years, male. Cough with pain in left chest; hemoptysis and dyspnea and wheeze for two years.

X-ray: Large shadow on left side.

Bronchoscopy April 26, 1933: Large mass in left bronchus almost filling entire lumen. (Picture No. 5.)

Biopsy: Epidermoid carcinoma Grade II.

Case 6

A. K., male, aged 53 years; Newark City Hospital. Cough and hemoptysis with dyspnea.

X-ray: Shadow on left side.

Bronchoscopy June 13, 1933: In the left bronchus below the upper lobe bronchus, a large mass, bleeding readily on contact. (Picture No. 6.)

Biopsy: Rapidly growing endothelioma.

Case 7

7384-0; J. L., male, aged 51 years. Had been treated for bronchitis with pain on right side, accompanied with cough, hemoptysis, loss of weight and dyspnea.

X-ray: Right-sided lesion.

Bronchoscopy Nov. 16, 1930: In the right bronchus, just below the middle lobe bronchus, the bronchus was occluded by a grayish white growth, bleeding readily on contact. (Picture No. 7.)

Biopsy: Papillary carcinoma of bronchus.

Case 8

7863-0; A. Mc., male, aged 50 years. Has been treated for bronchitis and tuberculosis for four years. Pain in right chest with cough, hemoptysis, dyspnea.

X-ray: Atelectasis right side.

Bronchoscopy June 24, 1931: Right bronchus, below the middle lobe bronchus, springing from the lateral wall of same was a mass almost completely plugging right stem bronchus. (Picture No. 8.)

Biopsy: Undifferentiated carcinoma.

Case 9

8125-0; M. Mc., male, aged 24 years. Was gassed in France; mustard gas. Had been treated for cough for some time with pain in right side and shoulder, with hemoptysis, loss of weight and dyspnea.

X-ray: Nodes in chest, neck. Diagnosis: Unresolved pneumonia.

Bronchoscopy December 3, 1931: Carina sharp. In the right upper lobe considerable pus coming from it with granulations. (Picture No. 9.)

Biopsy: Squamous cell carcinoma, Grade II.

Case 10

3482-0; J. O'D., male, aged 34 years. Cough and pain on side with hemoptysis and dyspnea.

X-ray: Bronchus and trachea displaced to right.

Bronchoscopy June 15, 1927: Pedunculated growth on right side. (Picture No. 10.)

Biopsy: Low grade carcinoma.

Deceased three years after treatment.

Case 11

8656; M. R., female, white, aged 34 years, married. Had been treated for bronchitis and tuberculosis for three years.

X-ray: Malignancy of right lung with thickened pleura in right chest.

Bronchoscopy January 12, 1933: In the right bronchus, below the carina, the right bronchus filled with tissue. (Picture No. 11.)

Biopsy: Ulcerating papilloma of bronchus, Grade I.

Case 12

6699-0; F. S., male, aged 40 years, clerk. Had been treated for bronchitis for two years. Cough, loss of weight, dyspnea.

X-ray: Growth in left chest.

Bronchoscopy November 27, 1929: In the left bronchus, below the upper lobe bronchus, springing from an area about 7 o'clock, was a small growth which was removed. (Picture No. 12.)

Biopsy: Carcinoma.

Case 13

2176-0; G. S., male, aged 55 years, engineer. Pain in right side and chest, with cough, hemoptysis, loss of weight and dyspnea.

X-ray: Mass in right lower lobe.

Bronchoscopy March 3, 1932: In right bronchus, below middle lobe bronchus, stenosed, and over-growth of tissue, bleeding readily on contact. (Picture No. 13.)

Biopsy: Squamous carcinoma.

Case 14

9109-0; C. S., male, aged 52 years. Pain in left chest with cough, loss of weight, dyspnea.

X-ray: Consolidation on left side.

Bronchoscopy February 15, 1934: In the left bronchus, below the upper lobe, bronchus plugged with tissue. (Picture No. 14.)

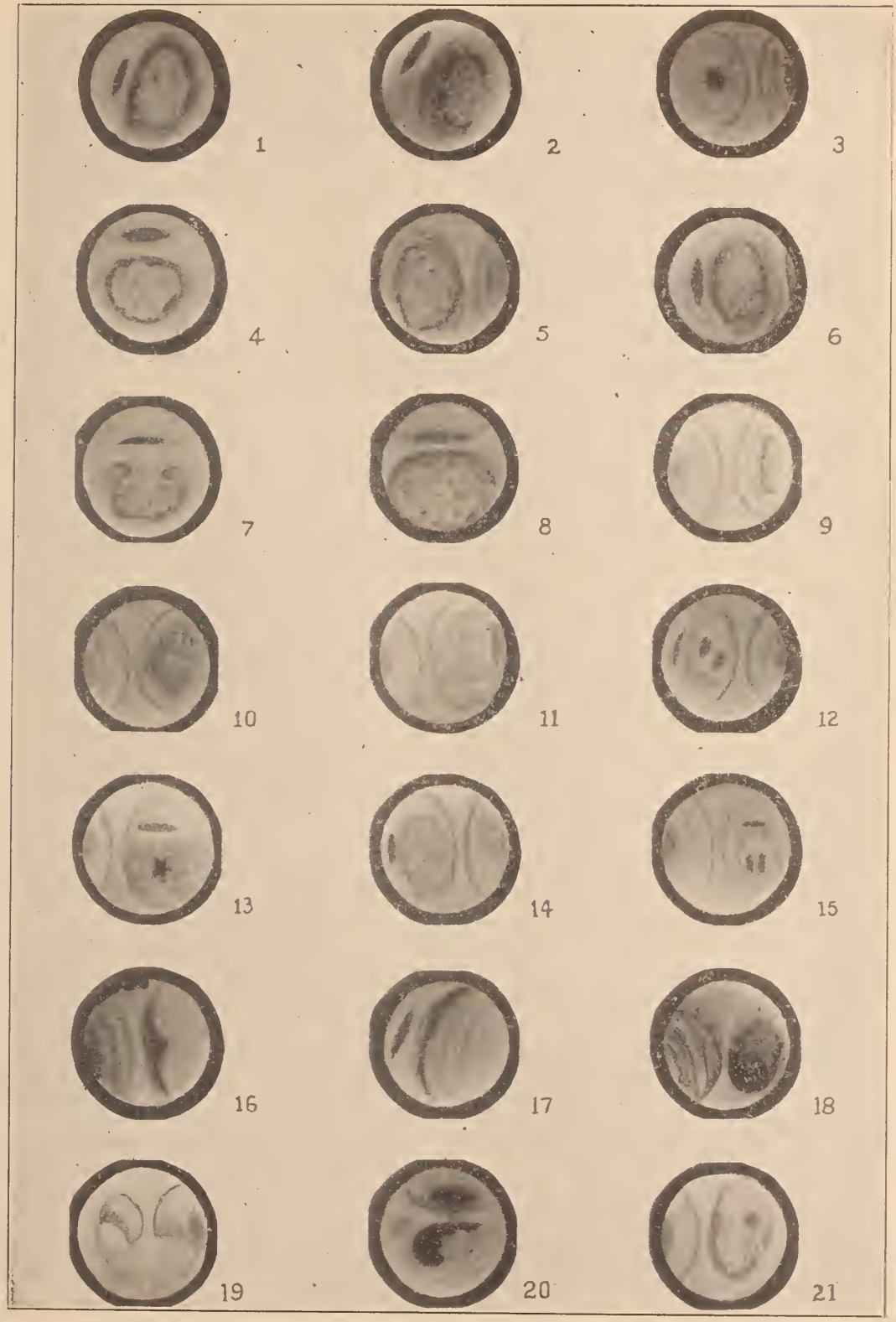
Biopsy: Carcinoma, Grade II.

Case 15

8549-0; H. T., female, aged 37 years, single. Cough, pain, substernal region; hemoptysis and dyspnea.

X-ray: Right side consolidation.

Bronchoscopy February 9, 1933: In the right bronchus, below the middle lobe, slight elevation of mucous membrane of



Bronchoscopic Pictures Illustrating Dr. Orton's Cases

different color. Clinical diagnosis: Early carcinoma. (Picture No. 15.)

Biopsy: None.

Deceased in six months.

CASE 16

M. C., Newark City Hospital, aged 55 years, male, white. Cough and dyspnea.

Bronchoscopy September 25, 1929: Right lateral wall of the trachea compressed from without. (Picture No. 16.)

CASE 17

8866-0; S. D., aged 45 years, male. Pain in left side with cough and loss of weight.

X-ray: Atelectasis of left side.

Bronchoscopy June 28, 1933: Left bronchus occluded by compression below the upper lobe bronchus. (Picture No. 17.)

CASE 18

8436-0; F. G., male, aged 40 years, fireman. Bronchial cough for one year; loss of weight and pain in right side of chest.

X-ray: Mediastinal tumor involving lung.

Bronchoscopy August 4, 1932: Posterior portion of carina sharp, anterior two-thirds thickened and fixed. The right bronchus contracted or stenosed from without. (Picture No. 18.)

CASE 19

8147-0; J. M., male, aged 56 years. Unproductive cough with dyspnea.

Bronchoscopy December 31, 1931: Growth pressing on the posterior wall of trachea on the left side, and the anterior wall of left bronchus, and inferior wall of right bronchus. Mediastinal tumor. (Picture No. 19.)

CASE 20

2011-0; C. B., male, aged 29 years, printer. Non-productive cough since 1918 following influenza. Had some pain at times on right side of chest, with dyspnea on exertion.

Bronchoscopy December 6, 1922: Growth pedunculated below middle lobe bronchus. This was removed bronchoscopically and patient is alive and well at present date. (Picture No. 20.)

Biopsy: Papillary carcinoma of bronchus.

CASE 21

2703-0. A. P., female, white, aged 47 years, married. Had been treated for tuberculosis. Pain at times in right side, cough and hemoptysis with dyspnea.

X-ray: Indicates the pressure of a large mass in right lung in region of middle lobe.

Bronchoscopy February 20, 1924: In the right bronchus just below the upper lobe was seen attached to the anterior bronchial wall, a pedunculated growth; fair amount of bleeding after removal. (Picture No. 21.)

Biopsy: Adenocarcinoma.

Alive and well at the present time.

CONCLUSIONS

1. Bronchoscopic findings are of unquestionable help to the thoracic surgeon and internist.

2. A close coöperation of pathologist, bronchoscopist, radiologist and thoracic surgeon is highly desirable for the most beneficial form of treatment.

3. Thoracic pain, cough, dyspnea and hemoptysis, are of diagnostic value in carcinoma of the bronchus.

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THE CLINICO-PATHOLOGICAL CLASSIFICATION OF CARCINOMAS OF THE LUNG

By Sylvan E. Moolten, M.D., New York City,
Pathologist to the St. Peter's Hospital, New Brunswick, N. J.

Read before the Section on Radiology at the 169th Annual Meeting of The Medical Society of New Jersey, on May 2, 1935, in Atlantic City, in a Symposium on Primary Carcinoma of the Lung

The roentgenologist has more than an ordinary responsibility in the roentgen diagnosis of carcinoma of the lung. It is not sufficient to say that a tumor is present, for he must be prepared to give an opinion concerning the *operability* of the tumor. The present tendency undeniably is to classify lung tumors at once into "surgical" and "non-surgical" categories.

To be considered "surgical" a lung tumor must first of all be accessible, i. e., not too close to the hilum, and, secondly, should be removable *in toto;* i. e., there should be no metastases and no extensive invasion of surrounding tissues. It may be surprising to know that at least 25 per cent of all lung cancers at some time in their course are surgically removable. This compares quite favorably with the operability of cancers of the stomach and breast. The crux of the situation is *early diagnosis.*

In any discussion on the pathology of lung tumors, it is obviously impossible to omit the clinical implications of some of these growths. Take for instance the so-called "parenchymal" carcinomas. These are the circumscribed *round* cancers of the lung which develop within the parenchyma at a considerable distance from the main bronchi. These grow to an enormous size, but remain generally round, with sharply defined smooth or lobulated borders, and by their expansion cause pressure effects on the bronchial lumen. For a long time, however, they are clinically silent and may be first discovered accidentally during a routine fluoroscopy or roentgenogram of the chest. If these patients are watched over a period of months or years, the tumor will be seen to grow slowly larger by *expansion,* and by infiltration, preserving its round shape until it reaches the limits of the thorax. All this time the patient will have practically *no symptoms,* and will not cough or expectorate or bleed, will not lose weight or strength, and may only have some shortness of breath on exertion when the tumor is very large. Except for slight external pressure on the bronchi when the tumor has grown to a large size, *bronchoscopy is regularly negative.* Even at autopsy the bronchi will be shown to extend into the growth for a considerable distance without much change in their lumen.

It is important not to wait for a positive bronchoscopic biopsy before operating, since by that time there will have appeared metastases, usually blood-borne. It may be permissible to do a needle biopsy of the tumor, however. These tumors are ideal from the standpoint of surgery since, usually, they are sharply circumscribed and fairly superficial, often producing a rounded bulge on the pleural surface with a central dimple. Cut section through the region of this dimple may at times reveal an area of dense scar tissue with anthracosis, from which the tumor may have arisen. Microscopically these carcinomas are mostly anaplastic squamous cell carcinomas, but some are formed of rather large pale cells which have a strong resemblance to the pavement cells lining the alveoli of the embryonal lung. Sections taken through the edge of such tumors show a well defined line of demarcation from the surrounding lung tissue, which is compressed but not appreciably infiltrated.

The complications of the parenchymal carcinoma are few. Metastases are usually late and few, and are usually extra-thoracic; e. g., in the brain, bones, and so forth. Occasionally such round tumors become softened centrally and degenerated into *cavities* which in the x-ray film show a peculiarly dense thick wall, distinguishing them from simple lung abscess. Only in these cases will the patient bring up blood or sputum and show evidences of toxemia. At times autopsy shows almost complete destruction of the tumor except for its outer edge.

Another important lung tumor which may be operable is a type which begins its growth in a *small bronchus* near the pleura, and grows in an *infiltrating* manner toward the chest wall, producing a localized "pneumonic" shadow on the x-ray plate. When the tumor grows to a huge size the x-ray film may show a dense consolidation in which the lower order can no longer be visualized, and the chest wall may have become invaded with destruction of ribs. In such cases the patient will complain of continuous, severe pain. This grows more rapidly than the parenchymal carcinoma and produces symptoms very early because of its rapid invasion of the overlying chest wall. The important symptom in this type of carcinoma is *pain,* persistent, severe, increasing. There may be little or no cough or sputum or bleeding, but an important diagnostic sign is the presence of clubbing of the fingers. In all such cases surgery should be tried if possible because theoretically at least no metastases may as yet have developed. Here too bronchoscopy may prove negative because of the small size of bronchus involved, particularly in the upper lobes. If bronchoscopy is negative, needle biopsy of the chest wall may be necessary to rule out "encapsulated empyema" or "actinomycosis". These tumors may arise anywhere within the lung; e. g., on the diaphragmatic surface posteriorly causing localized backache, along the anterior lung border growing through the sternum, or in the apex of the lung to invade the supraclavicular fossa and root of the neck to produce the clinical syndrome so well described by Pancoast as "superior pulmonary sulcus tumor". I am inclined to differ with Dr. Pancoast in only one respect, that of the point of origin of these tumors. In all the cases I have seen with Dr. Wessler and Dr. Rabin at the Mount Sinai Hospital in New York, autopsy has shown their origin within the lung, usually in a small bronchus, quite near the pleura. When the bronchus of origin is somewhat larger, the infiltration resembles tuberculosis roentgenologically. If such a localized branch bronchus tumor is resected early together with overlying pleura, rib, and muscle or diaphragm, the patient may conceivably be saved.

There are certain occasional lung cancers which arise in small bronchi which, however, do not remain confined to their point of origin but very quickly enter the lymph or blood stream, causing early death through metastases. These may be called the "diffuse" type of peripheral bronchus carcinoma. The "localized" type, which I have just described, however, as well as nearly all carcinomas of the parenchymal variety may be considered together practically under the single heading of "circumscribed" lung tumors which are primarily operable. As I have said already, these circumscribed tumors comprise nearly 25 per cent of all lung tumors.

Of the remaining 75 per cent of lung cancers, 62 per cent are those which arise in the main bronchi or their primary divisions.

Just as in cancer developing anywhere else, cancers arising in the large bronchi may be bulky, and expend most of their growth energy locally, or they may be flat and insignificant at their point of origin but develop enormous metastatic growths elsewhere. We have an analogy in the "cauliflower" or "encephaloid" type of carcinoma of the stomach, which produces an enormous, soft, fungating mass which ulcerates and bleeds profusely, yet may be amenable to surgery because there are no metastases, and, in marked contrast to that, the small flat infiltrating carcinomas of the stomach producing a "scirrhous" lesion or merely a diffuse interstitial infiltration of the stomach with contraction, the so-called "leather-bottle" stomach or linitis plastica, associated with widespread metastases throughout the peritoneum and elsewhere. The majority of cases fall somewhere in between these two extremes. The same thing is true of bronchial carcinomas.

I. The *average* type of carcinoma of the large bronchi is represented symptomatologically by cough, bloody sputum, fever, and wasting. Clubbing of the fingers is present. Roentgenologically one notes a triangular tapering shadow at the root of the lung with an associated atelectasis or pneumonic infiltration and with enlargement of the mediastinal lymph nodes. Bronchoscopy shows an area of narrowing in the bronchus by granular or

ulcerating fungating tumor tissue growing into the lumen and bleeding easily. At autopsy the tumor is found to have grown through the bronchial wall into the surrounding lung tissue, spreading also along the lymphatics toward the pleura ("carcinomatous lymphangitis"), or toward the mediastinum involving the lymph nodes. The phrenic nerve is often compressed, paralysing the diaphragm, also the left recurrent laryngeal nerve, paralysing the left vocal cord. Within the lung there is generally found considerable secondary inflammation with suppuration and abscess formation due to various bacteria; e. g., pneumococci, streptococci, staphylococci, colon bacilli, various anerobes (including Vincent's organisms), also fungi such as the aspergilli. The appearance is that of bronchiectasis, or atelectatic bronchopneumonia with carnification, or both.

II. Among the less frequent deviations from the average type may be noted a *more localized,* or *"cauliflower",* type. This produces a solid massive infiltration within a small radius of the primary focus in the bronchial mucosa and infiltrates the regional lymph nodes to some extent but may exhibit few metastases. On the other hand, it tends to develop a marked degree of bronchial obstruction resulting in atelectasis, bronchiectasis, or extensive secondary infection with suppurative pneumonia or lung abscess, empyema, or pyopneumothorax. To the clinician this type often masquerades as "unresolved pneumonia".

III. In contrast to this type is a carcinoma which might be called the *"pseudo-pneumonic"* type. Here one sees at autopsy a solid infiltration of one or more lobes of the lung with dense tumor tissue. On x-ray examination this may also be considered "unresolved pneumonia", perhaps with "effusion". In such cases there is little sputum, much dyspnea, and clubbing is often present.

(I feel quite definitely that the term "unresolved pneumonia" is used much too loosely, since a primary *lobar* pneumonia which fails to resolve is an extreme rarity if it exists at all. In most cases where this diagnosis is offered one should suspect bronchiectasis, tuberculosis, fungus infection, foreign body in the bronchus, or *neoplasm.*)

IV. The next type of bronchial tumor to be considered is very important from the point of view of clinical diagnosis. This is the *"submucous"* type of Wessler, analogous to the non-ulcerating scirrhous carcinomas of the stomach, especially the type called "linitis plastica". The predominant tendency in this type of carcinoma is for *interstitial* infiltration with rapid and marked invasion of lymphatics and widespread metastases. This type of carcinoma is frequently composed of very small cells, and may be mistaken by the pathologist for lymphosarcoma or fibrosarcoma, but is really a form of very unripe spuamous cell carcinoma. This type includes the so-called "oat cell" tumor of the lung. The important thing about this type of tumor is its insignificant primary focus. It is often missed bronchoscopically. The experienced bronchoscopist, however, may decide to take a punch with his forceps from the mucous membrane at a certain point merely because "it did not look quite right", it did not present the usual pliability and folds, perhaps seemed slightly thicker than normal, and yet in no sense of the word did it resemble a tumor. In such cases there may not even be a narrowing of the lumen or a rigidity of the bronchial wall, and, since the mucous membrane is practically intact, the patient will have no bronchial irritation and therefore no cough, likewise no sputum, and no hemoptysis,—none of the classical symptoms of lung cancer. In the early stages of the disease even the x-ray plate may be negative. At this stage, nevertheless, the mediastinal tissues will have already become *permeated* with carcinoma cells in a diffuse manner, with pressure on nerves, for instance, causing hoarseness, or paralysis of one-half of the diaphragm.

Soon afterward important symptoms appear, which, for the most part, are not respiratory symptoms.

A. The chief flow of tumor cells may be toward the mediastinum, resulting in a large mediastinal tumor which on x-ray examination suggests lymphosarcoma. At autopsy not only are the lymph nodes themselves massively swollen with tumor cells, but all the mediastinal interstitial soft tissues are similarly infiltrated, so that all the mediastinal viscera become

firmly encased in tumor. This appearance might well be called the "frozen mediastinum". The esophagus, in part, may become greatly compressed and fixed in a rigid encasement of firm tumor tissue, as may the superior vena cava, phrenic, vagus, sympathetic, and laryngeal nerves, the pericardium, and even the heart itself.

B. In other cases of this *interstitial* type (or "submucous" type) the chief flow of tumor cells may be toward the periphery away from the hilum, with the formation of a dense mantle of tumor tissue around most of the bronchi and blood vessels leading away from the primary focus, the so-called "carcinomatous lymphangitis". In this type the pleura is quickly involved and massive effusions appear.

Many cases of bronchial carcinoma, particularly cases of the "submucous" or interstitial type, produce metastases long before the primary focus becomes clinically evident within the lung. Carcinomas of this type seem to display a remarkable metastasizing tendency, and one might even speak of a "carcinoma sepsis". In these cases the primary pulmonary origin may remain hidden until autopsy is performed. This type of tumor furnishes the chief source of so-called "cryptogenetic" carcinomatosis; i. e., without known primary focus. Its closest rival is probably carcinoma arising in the body or tail of the pancreas.

The metastases in these cases may be nodular, miliary, submiliary, or diffuse, and practically every organ and structure in the body may be involved. The brain, bones, lymph nodes, liver, and skin are particularly predisposed, but organs which are rarely the seat of metastatic deposits from tumors of other origin are frequently involved in these bronchiogenic carcinomas. These include the adrenals, the stomach, the small and large bowel, the gallbladder, the pancreas, the meninges and nerve roots. The metastases may be isolated deposits, which, in the case of the intestine, may cause significant obstruction, or they may be diffuse and show no recognizable sign of their presence grossly, merely increasing the size and firmness of an organ (e. g. pancreas) in a more or less uniform manner. In the latter case the tumor cells are only demonstrable microscopically and are seen to be filling the lymphatics and stroma.

It must be obvious that no form of surgery directed upon the primary focus could have the slightest benefit in cases of this type.

In this connection I should like to say a few words about a certain tumor which is often reported by pathologists as being malignant but which in reality is benign. This is the benign adenomatous polyp of the bronchus, described in 1932 by Wessler and Rabin. A number of "cures" of "carcinoma" of the lung have been reported in the literature following surgical lobectomy or implantation of radium bronchoscopically. Study of the histological illustrations in these cases would make it seem that many or most of them were really benign adenomas incorrectly called malignant. These patients would be just as well today if the tumor were merely punched away by the bronchoscopic forceps, with, perhaps, a certain amount of local diathermic fulguration as employed by Dr. Kramer of the Mount Sinai Hospital in New York where twenty-three such cases have been discovered to date. These are probably true *adenomas* and not "inflammatory polyps" as suggested by Konzelmann, nor "endotheliomas" or "angioendotheliomas" as often reported by other pathologists. In contrast to the vast majority of carcinomas, which are almost never associated with polypoid growths into the bronchial lumen, these tumors are always large, smooth, pedunculated or semi-pedunculated polyps, usually covered with mucous membrane, and often completely filling the lumen of a large bronchus. In contrast to carcinoma, they occur twice as often in women as in men. The average age of the patient at the onset of symptoms is twenty-nine years. The duration of known symptoms may be many years (in one case thirty-four years). Autopsy in five cases showed that death was caused only indirectly; e. g., by secondary bronchiectasis or by hemorrhage, and in none were metastases found. The symptoms of benign bronchial adenoma are often so clear-cut clinically that the experienced observer will more often than not make the correct diagnosis before bronchoscopy. In general, the symptoms are those of marked bron-

chial occlusion of many years' duration (atelectasis plus infection), and clinically usually typical of bronchiectasis with or without wheezing, associated with hemoptyses. The hemoptyses are characteristically profuse and paroxysmal (in marked contrast to the steady slight ooze of dark red blood with clots seen in carcinoma of the bronchus). In women the hemoptyses are often coincidental with menstrual periods.

I should now like to mention something of the complications of bronchial carcinoma, one of the most interesting phases of the entire subject. First of all is infection, and as in all carcinoma, there is a marked predisposition in lung cancer to secondary infection. According to Graham, of 178 cases of pulmonary suppuration which he reported in 1926, ten per cent were found to be due to carcinoma, although clinically they were classed as pulmonary suppuration (lung abscess, bronchiectasis). Secondary suppuration of the lung may also lead to suppurative empyema, and this may be the presenting feature of the case. Not infrequently an empyema sinus will fail to close, may bleed excessively, or may re-open spontaneously after apparent healing. One should not be too greatly surprised if autopsy or bronchoscopy should reveal carcinoma in such a case.

Besides empyema, a simple serous effusion into the pleura may be the first clinical sign of carcinoma of the lung. In general, in an older individual, any pleural effusion without obvious cause should be considered the result of carcinoma until proved otherwise. An important diagnostic help in such cases is that described by Mandlebaum in 1917, according to which the centrifuged sediment from a suspected effusion is fixed and embedded in paraffin; from this slides are cut and stained just as with any tissue and examined microscopically for tumor cells. Pleural effusion in lung carcinoma may be caused by secondary infection of the lung, by venous obstruction, by metastases of tumor to the pleura, or by direct extension of tumor to the pleura either along the pulmonary lymphatics or from the mediastinum into the subpleural lymphatics.

The mediastinum is a particularly vulnerable site in lung carcinoma and the mediastinal lymph nodes are usually invaded by carcinoma originating in the large bronchi soon in its course. Pressure effects are produced either by bulky metastases to these lymph nodes or by extension of the tumor itself along the wall of its parent bronchus. An important type of mediastinal involvement is that which I spoke of previously as the "frozen mediastinum". This occurs particularly often in carcinomas of rapid growth, particularly the "submucous" type.

The esophagus may become considerably narrowed in its mid-portion and cause difficulty in swallowing. In a few cases ulceration occurs and produces a fistula between the bronchus and the esophagus. In one such case an esophageal lesion was suspected by the physician rather than a bronchial carcinoma. The patient was given barium to swallow, and x-ray films of the chest showed barium outlining most of his bronchial tree. Needless to say, he soon died of gangrenous bronchopneumonia.

Compression of nerve-trunks within the mediastinum leads to certain clinical phenomena of great importance in diagnosis. Paralysis of one-half of the diaphragm may be the first evidence of bronchiogenic malignancy, even before cough. Pain in the corresponding shoulder may be present. The phrenic nerve is probably never involved in adult tuberculosis. If signs of phrenic nerve paralysis appear in an individual with tuberculosis, they should be regarded as ominous and probably indicative of silent bronchial carcinoma. A similar importance attaches to paralysis of the left inferior (recurrent) laryngeal nerve which is associated with hoarseness and a brassy cough. However, this is noted in other conditions, such as mitral stenosis, aortic aneurysm, and certain cases of coronary thrombosis. Compression of the vague nerve undoubtedly occurs, but its clinical symptomatology is by no means definite. Vague abdominal symptoms, belching, and distention, which occur in some cases, may possibly be explained on this basis. Paralysis of the sympathetic nerves may be more definite, especially in the case of the cervical sympathetic ganglia and chain. This is characteristically found in apical lung tumors which in-

vade the root of the neck (e. g., Pancoast type) and is known as Horner's syndrome. There may be additional involvement of the brachial plexus so that the patient complains of shooting pains down the arm, paresthesias, weakness, and so forth. The Horner syndrome may be present in either of two forms, an "irritative" form with dilatation of the pupil, widening of palpebral fissure, and slight exophthalmos, or the more common "paralytic" form with contraction of the pupil, drooping eyelid, enophthalmos, and unilateral loss of sweating in the face and neck.

Compression of the great veins in the mediastinum produces one of the most striking features of the mediastinal syndrome. The head, neck, and upper extremities are characteristically congested, cyanosed, and somewhat edematous, the superficial veins are markedly prominent and distended, and the subject complains of great distress and feeling of suffocation, being unable to lie flat. The clinical picture would suggest a severe degree of right heart failure except for the fact that the liver is not swollen nor the lower part of the body edematous. True right heart failure is exceptional as a result of lung tumor, but may occur when sufficient narrowing of the pulmonary arteries is produced to interfere with the function of the right ventricle. More often the pulmonary veins are compressed and parts of the lung are subjected to considerable congestion and edema.

Direct cardiac complications of lung tumors are not infrequent and render clinical diagnosis extremely difficult. The roentgenogram may show the typical appearance of ordinary pericardial effusion, and autopsy will demonstrate metastases to the pericardial surfaces. I should like to discuss four syndromes of metastatic tumor of the heart. The first is the "syndrome of infiltration of the auricle with contraction" and is due to the creeping down of tumor cells from the upper mediastinum into the wall of the right or left auricle. As the auricle becomes more and more infiltrated it shrinks in size until its cavity is too small to accommodate the normal flow of blood. If the left auricle is involved, the picture resembles that of a tight mitral stenosis, and if the right auricle is involved, that of tricuspid stenosis, and the patient will die in heart failure. The second is the "syndrome of ball-valve thrombosis of the auricle" and is produced by the growth of tumor into the auricular chamber in such a manner that mechanical plugging results. Clinically the patient presents the picture of sudden vascular shock in which the extremities become cold and pulseless, the blood pressure very low, and the skin extremely pale and cyanosed. The picture is incomplete, however, unless at the same time there is noted a marked degree of cyanosis of the tips of the fingers and toes, the tips of the ears, and the tip of the nose; this may go on to actual partial dry gangrene of these parts. Autopsy shows mechanical obstruction of the left auricle with either thrombus or tumor. The next syndrome is the "syndrome of metastatic tumors of the auricle" in which, as described by Fishberg, an uncontrollable auricular fibrillation or flutter appears and autopsy shows metastases to the region of the sino-auricular node. The fourth is the "syndrome of coronary disease" in which metastases to the sheath of the coronary artery appear to be the cause of angina pectoris of marked severity and frequency of attacks.

"Latent" cases of lung cancer comprise about 15 per cent of the total number. These are the cases in which the first symptom may be metastasis to some extrathoracic organ such as the brain. One of the characteristics worth remembering of metastatic tumors of the brain is the sudden onset of symptoms in contrast to the gradual onset in primary brain tumors. This suggests a vascular complication of some sort. Metastases to the meninges and nerve roots may be of miliary size, so that symptoms may for a long time be those of "multiple neuritis" or "meningoradiculitis".

Bone metastases are frequent, and in some cases produce huge spindle-shaped deformities of ribs or long bones. At times the osseous infiltration is diffuse rather than nodular, and certain writers believe that many cases of Ewing's tumor or "endothelioma" of the bone are really instances of metastasis from primary carcinoma of the bronchus (Hirsch and Ryerson).

The enormous liver produced by metastases

in some cases may suggest clinically primary carcinoma of the liver. Metastases to the gastro-intestinal tract, as I mentioned before, may be important as sources of intestinal obstruction; recently I saw at autopsy three separate instances of this kind in which metastases were seen in the jejunum, ileum, and sigmoid colon. Metastases to the pancreas may be nodular or diffuse. In one case of the "submucous" type the pancreas at autopsy seemed unusually large and firm, but otherwise appeared normal. Microscopically it was infiltrated with tumor cells, especially in its interstitial tissues, and while the acini were more or less intact, many islets of Langerhans were partly atrophied. During life this patient showed evidences of moderately severe diabetes. Involvement of the adrenals, on the other hand, rarely produces clinical evidences of Addison's disease despite a marked degree of involvement. This is explained, I believe, by the persistence in most such cases of a sufficient fraction of adrenal cortical tissue for functional requirements.

Besides the wasting, fever, and anemia of most advanced cases of lung cancer, certain other phenomena may appear which I might class together with these as "metabolic" complications. Amyloidosis of the viscera is occasionally seen. A peculiar tendency to thrombosis is another feature of some cases. One may use the term "thrombophilia" for these. There may be seen an isolated thrombophlebitis of one of the superficial veins for no outwardly apparent cause, or several veins may become thrombosed in the manner of a thrombophlebitis migrans. In some cases death may be brought about fairly rapidly by an acute coronary artery thrombosis. In such cases tumor cells cannot be found in the wall of the thrombosed vessel, and one must assume some peculiar change in either the blood clotting mechanism or in the vessel wall or both. This phenomenon is by no means restricted to pulmonary cancer, but occurs in many others as well. One other general phenomenon of great special importance in the diagnosis of carcinoma of the lung is clubbing of the fingers and toes. One might make it a maxim that in any case of pulmonary disease in which the diagnosis of either lung abscess or of bronchiectasis is not clear-cut, the presence of clubbing of the fingers should at once lead one to suspect carcinoma. So far no one has satisfactorily explained the cause of clubbing, and I can see no particular relation between the type of lung carcinoma and clubbing. I can only say that a very definite association exists which cannot be disregarded.

Concerning the histology of lung carcinoma I have very little to say, since from what I have been able to learn, there is no significant correlation whatever between the gross and the microscopic features of lung cancer with certain few exceptions. A slowly growing bronchial carcinoma with relatively few metastases is more likely to be a squamous cell carcinoma with pearls, whereas a rapidly growing infiltrating carcinoma, particularly one of the "submucous" type is more likely to be a very immature squamous cell carcinoma without pearls and with small cells of round or "oat" shape. From the standpoint of the clinician the most important thing for the present is to be aware of the possibility that a benign adenoma may be diagnosed incorrectly as a malignant tumor.

THE SURGICAL TREATMENT OF PRIMARY CARCINOMA OF THE LUNG

By Richard H. Dieffenbach, M.D., Newark, N. J.

Read before the Section on Radiology, at the 169th Annual Meeting of The Medcial Society of New Jersey, on May 2, 1935, in Atlantic City, in a Symposium on Primary Carcinoma of the Lung

After the diagnosis of primary malignancy of the lung has been made, the question of treatment arises. Naturally, we must employ all measures at our command to ascertain that there are no contraindications, such as distant metastasis, marked mediastinal involvement, secondary growth in the contralateral lung, extensive involvement of the chest wall, and that the general condition of the patient is such as to warrant the attempt at radical extirpation.

The results of deep x-ray and radium therapy have not been satisfactory. Tudor Edwards, of London, England, has employed special containers for radium application, and reports good paliative results.

Several "cures" have been reported following the removal of growths endoscopically. These were reported by Chevalier Jackson, Yankauer, Orton, Kernan and Cracovaner, Greene, and Arbuckle. Unfortunately, there seems to be some discussion regarding the exact microscopic diagnosis in some of the above. In fact, as we review the literature on malignancy of the lung, especially as regards biopsies obtained by the bronchoscope, one is impressed by the difficulty in making a positive diagnosis of malignancy. It is my impression that, at a later day, after more has been learned regarding lung malignancy, we shall find that pulmonary tissue reacts somewhat differently than does other tissues, and we may find growths comparable to the carcinoid tumor of the appendix.

When we have decided on the surgical removal of a malignant growth of the lung, we must employ a procedure which will permit wide removal of the growth with the examination and extirpation, if necessary, of the lymph glands. There are only two operations fulfilling these requirements, namely lobectomy and pneumonectomy. Both of these have been successfully performed in man, and great credit is due to the pioneers in this field.

The first lobectomies were usually performed in two or more stages. A long intercostal incision is made in the fifth, sixth, or seventh interspace, and the chest cavity opened. The extent and location of the growth is then determined, and if found suitable for removal, some method for causing pleural adhesions, in order to obliterate the pleural space between the uninvolved lobe or lobes and the chest wall is instituted. The affected lobe or lobes are surrounded by rubber tissue or other measures taken to prevent adhesions. The chest wall is then closed under positive intra-pulmonary pressure and usually no drainage established. The thought behind this method is to prevent the infection of the entire pleural cavity when finally the involved lung is removed. The method is useful, therefore, particularly in those cases where there is superimposed infection, such as abscess formation or bronchiectasis. In ten to fourteen days the incision is reopened, and the involved area removed after mass ligation, or is simply ligated and allowed to slough away. There are several finer modifications such as closed drainage, tight closure, suction, permanent or temporary phrenic interruption, etc., which, in the time alloted, it will be impossible to discuss.

Now, this method gives very little opportunity to adequately inspect or remove secondary glandular involvement, and secondly, does not permit of a high ligation of the pedicle.

I have not mentioned anything about the dynamics of an open pneumothorax, nor have I discussed the various methods of anesthesia in this type of surgery. This would take us too far afield, and I know that you are undoubtedly familiar with the various methods and the underlying principles. There has, however, been one outstanding contribution to this field which I feel merits particular stress, and that is the creation of an artificial pneumothorax preliminary to lobectomy or pneumonectomy. This not only causes the involved lobe or lobes to shrink in size, and therefore materially assist in their removal, but at the same time accustoms the patient to breathe with a diminished lung area and, to a certain degree, fixes the mediastinal structures. The pneumothorax should be as complete as possible, keeping the pressure at zero or slightly negative, and should be induced ten or fourteen days before the radical removal is undertaken. This can, of course, be employed only when the pleural cavity is free of adhesions.

There are now several methods of lobectomy and lung removal for us to consider. After the preliminary pneumothorax, a one-stage operation is the rule. It may be done through a long intercostal incision with mass ligature and removal. It may be done by using special tornique snares at the root of the lung and cutting between them. This latter modification is a great help in lobectomy because the root of the lobe or lung may be steadied in the snare and the structures carefully ligated, sutured, and inverted.

The latest addition to radical lung removal or lobe resection is the anterior approach. Here the usual preliminary pneumothorax is induced. Then, after a period of ten to fourteen days, an incision is made antero-laterally in the third interspace, through the pectoral muscles and dividing the intercostals. The pleura is incised, and a rib-spreader inserted. This leads directly to the root of the lung, particularly on the left side, and, as the pulmonary artery and vein are anterior to the bronchus, these may be ligated first, and the bronchus treated later. Reinhoff and Broyles report two successful cases, and Overholt two others operated by this method. The approach is more suitable for the left side than the right on account of the anatomical relations. On the right, the pulmonary artery and vein divide almost immediately into three or four branches, instead of one or two, as on the left side. The right stem bronchus also divides quickly into an eparterial, middle, and lower, so that several ligatures must be passed, instead of two or three.

This sketches, very briefly and superficially, the technic of lobectomy and pneumonectomy. There are a few controversial points which I would like to bring to your attention.

The closing or covering of the bronchial stump is very important. Probably the best method, after ligation, is to cover the same with a portion of lung or pleura, as we are accustomed to reinforce a suture in the abdomen with a bit of omentum.

The question of closed drainage or no drainage is another mooted question. This, of course, is also dependent upon concurrent infection. Naturally, if there is any spilling, drainage is indicated, but aside from infection, there is the possibility of the bronchial ligature blowing off and creating a tense pneumothorax, and also the danger of concealed secondary hemorrhage. I would, therefore, lean toward closed drainage.

Another question is that of thoracoplasty following a pneumonectomy to obliterate the dead space. After a lobectomy, this problem does not as a rule arise. Some thoracic surgeons advise a thoracoplasty following pneumonectomy, and others do not, claiming that the pneumothorax will gradually eliminate itself to a great extent, and, if it remains sterile, will cause no symptoms. This question, in my opinion, must be judged individually in each case. A young person, with no infection and a yielding chest wall, may do well without a thoracoplasty, whereas with an infected pleural cavity and rigid chest, a collapsing operation would have to be considered.

I have not mentioned some of the so-called palliative procedures which have been employed to relieve excessive intrapleural pressure caused by a neoplasm. These, of course, are last resorts, and consist of some form of a decompression as removal of ribs, and splitting the sternum. There are also the various nerve blocks and sections for the relief of pain, and at times it may be necessary to drain a secondary suppuration.

The question of anesthesia has not been settled. Shenstone has employed high spinal. Some prefer avertin and nitrous oxide. Cyclopropane, a new inhalation gas, which may be given with a high percentage of oxygen, has been recommended by Overholt. In his two cases of pneumonectomy, the anesthetist, Dr. Sise, was able, by intratracheal anesthesia and hyperoxygenation, to practically suspend respiratory movements until the bronchus was closed. This, naturally, is a great aid to the surgeon. Personally, I have experience with high spinal in one lower lobe lobectomy, and it proved very satisfactory, but, as a rule, I prefer avertin and nitrous oxide-oxygen. A method of closed anesthesia is most desirable, and probably the intratracheal method is the best. Local anesthesia may be employed for the first stages, but, during pedicle ligations, the patient should, in my opinion, be under a general anesthesia.

This has been a very superficial and sketchy presentation, and I must apologize. If I may, however, leave a few thoughts with you, I feel that you will not have wasted your time entirely.

In the first place, an early diagnosis is essential. This can usually be made, after a careful history and physical examination, by roetgenography and fluoroscopy. If doubt exists, the following may assist in confirming

the diagnosis: Bronchoscopy, bronchography, biopsy by bronchoscope or punch aspiration, examination of the pleural fluid and sputum, and an artificial pneumothorax followed by a film and fluoroscopy. These measures also assist in deciding the extent and the operability of the lesion. If, however, after all these, or most of them, have been exhausted, and a doubt still exists, I would, if the general condition of the patient permits, strongly urge an exploratory thoracotomy. It is really surprising how little reaction follows this procedure, providing nothing more is done.

I feel that we can go a long way toward solving these problems and improving our results if the clinician, radiologist, bronchoscopist and surgeon will coöperate in this field of lung surgery.

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ROENTGEN THERAPY OF PRIMARY CARCINOMA OF THE LUNG

By Milton Friedman, M.D., Newark, N. J.

Read before the Section on Radiology, at the 169th Annual Meeting of The Medical Society of New Jersey, on May 2, 1935, in Atlantic City, in a Symposium on Primary Carcinoma of the Lung

In a consideration of the treatment of primary carcinoma of the lung, the chapter on the value of radium and x-ray is a short and sad one. The writer has never seen a case cured by this method; nor have any of the many radiotherapists who were questioned. There are many isolated published reports of successful cures, but a careful analysis of the evidence substantiating the diagnosis usually leaves some doubt as to its validity. On the other hand, palliation is frequently obtained, though only for a few months. Hemorrhage and hemoptysis may be arrested; pain may be lessened; the cough ameliorated; and the life of the patient prolonged. Occasionally, the reverse obtains, when the rapid progress of the disease may be catapulted to an earlier termination by radiation, or the symptoms of pain and weakness aggravated by radiation. This can be avoided by proper selection of the case for treatment.

Radiotherapy of bronchogenic carcinoma can be approached from three viewpoints: pathology, clinical types, and technic of treatment.

PATHOLOGY

Carcinoma of the lung has been subdivided into several degrees of malignancy depending upon the degree of differentiation of the cells and tissue architecture. The general laws of radiosensitivity are applicable to carcinoma of the lung, i. e., the more malignant the cell type, the more radiosensitive is the growth. However, all the primary carcinomata of the lung are very radioresistant, and consequently, they must be considered not in the light of their

radiosensitivity, but of their radioresistance.

From the standpoint of histogenesis, the tumors arising from squamous epithelium (ectoderm derivative) are less radioresistant than those arising from the glandular epithelium (entoderm derivative).

Bone metastases from carcinoma of the lung are more responsive to radiotherapy than the primary tumor, thus permitting the alleviation of pain and aversion of pathological fractures.

CLINICAL TYPES

The general condition of the patient, and the specific life history of the particular tumor must be considered in outlining treatment. In an anemic or cachectic patient, x-ray therapy is much less effective than in a patient of relatively good nutrition. This cachexia is usually due to the advanced stage of the disease, at which time there is found present a large volume of tumor tissue, which has become necrotic and secondarily infected, and is producing sepsis, anemia, and inanition. Symptoms referable to suppuration and necrosis rather than to neoplasia usually occupy the forefront of the clinical and pathological picture in the advanced stage of the disease. The response of this to x-ray therapy is similar to that of any other deep-seated, encapsulated infection, i. e., aggravation and lighting up of the condition. It is in this type of case that radiation therapy aggravates the symptoms of sepsis, pain, and cachexia, because the induced hyperemia increases the absorption of broken-down tissue, and the increased tension of the tissues enhances the pain.

Another syndrome wherein radiation therapy aggravates the condition occurs in early, small, intrabronchial lesions, which occlude the lumen of the bronchus and cause atelectasis. Irradiation of this atelectatic portion of the lung produces unfavorable general reactions. The patency of the lumen and aeration of the lung should first be accomplished by endobronchial removal of the mass with electrosurgery, before x-ray therapy is administered. Aside from the two abovementioned contraindications, all other cases of bronchogenic carcinoma should be irradiated.

The usual result of radiation therapy in the properly selected case is a curtailment of the pain and cough, and an improvement in the general condition of the patient. Roentgen evidence of shrinkage is rarely seen. Most commonly, a temporary arrest of the progress of the disease occurs. This arrest of symptoms last from two to seven months on an average. Often, there is a mild peripheral pneumonitis which encircles the area of noeplasm. The response of this infection to x-ray therapy frequently constitutes the pathological basis of the clinical response. Occasionally marked regression of the tumor does occur in the anaplastic types of squamous cell carcinomata, or in certain types of peripheral, small-cell, parenchymal carcinomata. That type of carcinoma which grows in the outlying part of the lung and invades the ribs early, producing the superior sulcus type of tumor when located in the apex is very radioresistant. In only one of four such cases treated by the author was there any slight partial relief of pain for a period of a few weeks.

TECHNIC OF TREATMENT

In the past, respect for the normal lung tissue has restricted the amount of x-ray therapy administered. However, within the past few years, the introduction of massive dose technics for the treatment of lesions of other parts of the body, wherein daily treatments of fractionated doses are given for a period of a month or so in order to produce a second degree burn of the skin which requires two or three weeks to heal has opened new fields in the treatment of radioresistant tumors. With this method, one is able to give three to five times as much radiation as was formerly given. The lung can tolerate this readily, provided there is not too much necrosis, infection, or atelectasis present. The palliative results of this type of treatment are definitely superior to those obtained in the past. This is an unexplored field and will require more time and experience before a proper evaluation of it can be made.

Radium packs have not proved to be superior to x-rays in the treatment of carcinoma of the lung.

THE TREATMENT OF THE FUNCTIONAL PSYCHOSES WITH FEVER THERAPY

A REPORT OF THE RESULTS OF 1598 CASES

By Robert G. Stone, M.D., Medical Director, and
J. B. Spradley, M.D., Clinical Director,
New Jersey State Hospital, Trenton, N. J.

The use of fever in the treatment of functional insanities followed the favorable results obtained in certain of the organic diseases, and was instituted at the New Jersey State Hospital at Trenton in 1928. The improvement obtained by fever has never been satisfactorily explained. Writers have suggested that fever changed the permeability quotient of the choroid plexus, or that it influences the coagulation and dispersion of the coloids, or perhaps the temperature inactivates the organisms found in certain of the foci of infection. Improvement as a result of the leucocytosis produced has been considered and some favorable results have been reported from the use of sodium nucleonate, a drug that causes a marked increase in the number of white cells in the blood; but, since we get equally as good results from malaria, which causes a reduction of the white cells, this explanation is undoubtedly incorrect. Histamine shock may be the explanation. So far, no theory offered is acceptable.

In the beginning of the treatment of functional psychotics with fever we employed foreign proteins injected intravenously, malaria therapy, and diathermy hyperpyrexia. With each method we were successful in producing the desired temperature; but because of the necessity of the expensive apparatus, trained technicians, and the time element required for treatment, we discontinued the diathermy method and limited ourselves to the foreign proteid and the malaria.

In May, 1932, in a paper read to the American Psychiatric Association, we reported the results of the treatment of 769 cases of functional psychosis by fever therapy. Since that time an additional 829 patients have been subjected to this treatment. Of this total of 1598 patients, 1321 received the intravenous proteids, 258 were given malaria, and 19 were subjected to diathermy hyperpyrexia. About 50 per cent were diagnosed *dementia praecox;* 35 per cent as *manic depressive insanity;* 10 per cent as *paranoid conditions* and *paranoia;* and 6 per cent as *psychoneurosis* and *toxic psychosis.* The average age was thirty-two years, and the average duration of the psychosis was nineteen months.

THE TYPHOID VACCINE REACTION

We selected typhoid inexed vaccines as our nonspecfiic proteid, because it was available, sterile, and inexpensive. Each cubic centimeter of this vaccine contained:

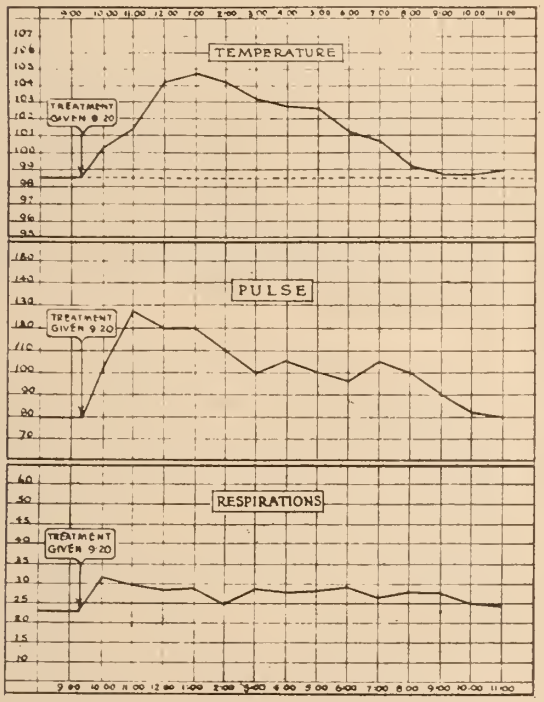
1000 million typhoid bacilli
750 million paratyphoid A bacilli
750 million paratyphoid B bacilli

We found that one-tenth c.c. of this mixed vaccine injected intravenously would cause the temperature to rise to a point varying from 101 to 105 degrees F. By varying the dose at each succeeding injection, this temperature could be reproduced, increased, or decreased as desired.

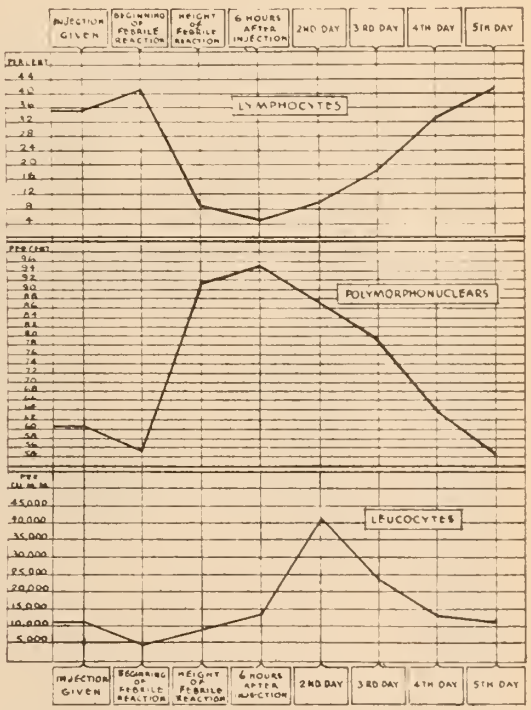
During the reaction the patients are confined to bed and are rather uncomfortable, sometimes nauseated, and frequently complain of chilly sensations. The day following the treatment they are out of bed, eat the regular diet, and show no after-effects. The treatment is *repeated weekly* for ten weeks. For various reasons not all of our patients were able to receive the complete ten weeks' course of injections, and we find that the average number of treatments for each of the 1321 cases reported here was 7.2, a total of 9500 treatments without a death or serious complication.

Approximately thirty minutes after the injection, we observe a definite chill resembling a malarial chill, accompanied by a rise in temperature. The maximum temperature is reached in two and one-half hours. It is main-

tained for about two hours, and then there is a gradual drop with a return to normal twelve hours after the injection. If the desired temperature of 104 to 105 degrees is not obtained with the initial dose of two-tenths of a cubic centimeter, we double the dose at the time of the next treatment and continue to double the dose at each treatment until the desired temperature is produced. After once determining the necessary dose to produce the desired temperature, we increase the dose two-tenths of a cubic centimeter at each treatment, as the patients develop a slight immunity, and the dose



Graph 1.—Temperature, Pulse and Respiration After Typhoid-Paratyphoid Injections



Graph 2.—Blood Picture in the Typhoid-Paratyphoid Method

must be increased in order to reproduce the 105 degree temperature. The maximum dose which is given is two cubic centimeters.

Graph 1 shows the average temperature change, based upon study of fifty fever charts; the highest temperature obtained was 106 degrees and the lowest, 101 degrees. The pulse and respiration curves are not significant, we see only the expected increase.

Graph 2 shows the usual change in the blood picture, including the average leucocytic count before treatment; the definite drop to leucopenia at the beginning of the reaction; the tendency to rise during the chill and elevation of temperature; and the definite leucocytosis at the end of six hours, followed by the extremely high leucocytic count twenty-four hours after treatment. Some of the studies show a leucocytosis of over sixty thousand, the average of fifty cases being slightly over forty thousand. Forty-eight hours after the injection this has dropped to about twenty-three thousand; and on the fourth day was down to twelve thousand and on the fifth day the count was back to normal.

The differential count shows an increase in polymorphonuclears parallel to the increase in the total white count. The polymorphonuclears rose to a maximum of ninety-five per cent six hours after the injection. On the second day they dropped to eighty-eight per cent; the third day to seventy-eight per cent; and the fourth day to sixty-three per cent; and the fifth day to fifty-four per cent, which was slightly below the sixty per cent found before the treatment.

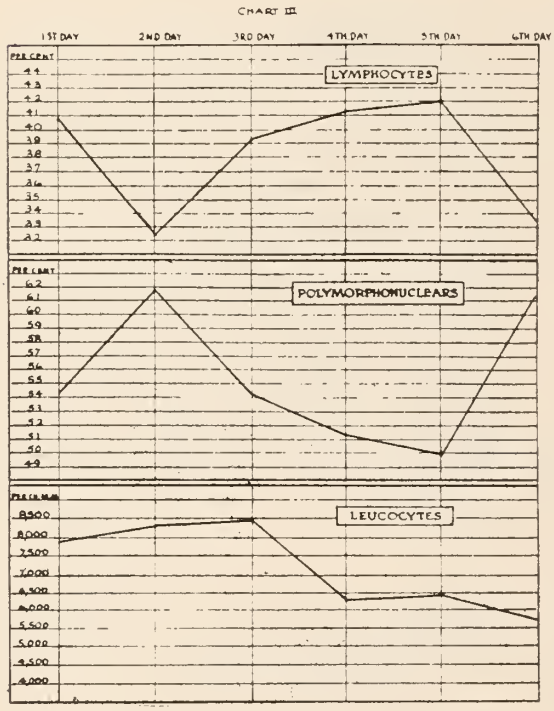
The lymphocytes naturally fell as the poly-

morphonuclears rose, and the lymphocyte curve is the reverse of the polymorphonuclear graph.

Blood chemistry studies, before, during, and following the treatment, show little change except a moderate increase in the blood sugar on the second day.

THE MALARIAL METHOD

The malaria is produced by injecting five cubic centimeters of blood taken from a donor who has an active malaria, into the median vein and subcutaneous tissues of the recipient. The disease develops in three to ten days. We have used both the tertian and the



Graph 3.—Blood Picture in the Malarial Method

quartian strains, but find the tertian more satisfactory for the production of fever, and more easily controlled. Some patients will develop daily chills, and occasionally one will suffer two chills within twenty-four hours. The majority, however, will have a temperature rise at regular intervals, every other day.

We allow the malaria to continue until the patient has had twelve or fifteen chills or temperature peaks, and it is then terminated with the intravenous injection of five grains of quinine, followed by quinine by mouth for seven days. Occasionally one of our patients showed a malaria relapse and subsequent rise of temperature, requiring additional quinine therapy.

The temperature of the malaria patients has ranged from 103 to 106 degrees. The white blood count showed little change compared to the leucocytic rise produced by the protein. There was a slight rise at the end of the third day followed by a drop on the fourth and a return to normal on the sixth. This leucocytic reaction was probably due to the protein content of the blood. The polymorphonuclears showed an increase on the second day, then a drop which reached its maximum on the fifth day with a second rise on the sixth day. Throughout the course of the malaria the differential count was without significance, there being less than a ten-cell variation from normal findings. The red cells showed a gradual diminuation in number as the disease progressed, but were never fewer than three million per cubic millimeter; and this secondary anemia disappeared rapidly after the malaria was terminated.

RESULTS OF TREATMENT

Observation of our 1598 patients treated by fever over a period of five years has convinced us that it is of definite value in the treatment of the functional psychotics. One of our first observations, which we reported in the original paper, was that depressed patients, particularly the involutional group, who refused to eat and required tube feeding, would begin to eat early in the course of the protein or malarial treatment. Fever has practically eliminated the necessity of tube feeding or forced feeding in our hospital.

There is also a lessening of agitation and long periods of sleep. We have also noted that it causes the extremely maniacal patients, who are rapidly exhausting themselves, to become less maniacal, less destructive, and more composed and coöperative. This improved behavior persists indefinitely after the fever is terminated. In the scizophrenic group the catatonic cases improve rapidly after the onset of the fever, and they seldom lapse back into the deep catalepsy noted before treatment. The episodes so frequently seen in the mental and constitu-

tional defective groups are terminated almost immediately by fever. This treatment has materially lessened the number of patients requiring constant supervision because of suicidal tendencies, and the number requiring isolation because of maniacal excitement. The average number of patients in isolation at presents is 74, in comparison with 105 patients prior to the use of this treatment.

An improvement in the mental condition of the patient accompanies the changes in the demeanor; and not infrequently recovered patients attribute their improvement to this treatment. Practically every case shows physical improvement as evidenced by a gain in weight, which has averaged six pounds one month after the termination of the treatment.

An analysis of the first 769 cases reported in May, 1932, showed that thirty-three per cent had at that time been released from the hospital and had made a satisfactory adjustment for periods ranging from four months to three years. The permanency of the improvement for this group is indicated by the fact that only six per cent have been readmitted.

An analysis of the 829 patients subsequently treated from January, 1932, to January, 1935, shows that thirty-five and one-tenth per cent have been released from the hospital and have adjusted satisfactorily in the community for periods ranging from six months to two and one-half years. An additional five per cent was released but subsequently readmitted to this hospital because of a return of mental symptoms.

Our cases were in no way selected. The duration of the psychosis varied from a few days to eleven years, and as is to be expected, the improvement occurred more frequently in the patients whose duration of illness was short. For purposes of comparison we selected one hundred patients with acute functional psychoses, the duration ranging from a few days to a few months, and subjected them to this treatment immediately after admission. This group showed encouraging results, with sixty-nine recovered sufficiently to leave the hospital within four months after their admission. A similar group of one hundred patients whose duration was five years or longer before admission was given the same treatment, the recovery rate being slightly less than fifteen per cent. This, we believe, shows conclusively that the results of this treatment vary directly with the chronicity of the disorder.

All of our patients, before receiving fever therapy, had been completely defocalized by the removal of infected teeth, tonsils, sinuses, gastro-intestinal toxemia, etc.; and had been given symptomatic treatment and special serums for other specific physical disorders. Many writers have reported results obtained with this type of therapy, but the number of cases studied by them was comparatively few, and the majority of their work has been on patients with psychoses of long duration. No one previously has completely defocalized the patients before instituting the fever therapy.

Our experience has convinced us that this form of treatment is responsible, to a large extent, for our extremely high discharge rate (for each one hundred patients admitted in a given year, forty-eight went out of the hospital as recovered or improved), for our comparatively low readmission rate, and for the comparatively negligible increase in the Trenton State Hospital population each year.

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HYPOTHYROIDISM

REPORT OF A CASE WITH MYXEDEMA

By MATTHEW MOLITCH, M.D., Jamesburg, N. J.
From the Department of Neurology, Medical School, University of Pennsylvania and the New Jersey State Home for Boys, Jamesburg

The diagnosis of hypothyroidism in the mild and advanced stage is discussed. Many gastro-intestinal and genito-urinary symptoms not reacting to accepted methods of treatment may be caused by deficient or absent secretion from the thyroid gland. A patient is reported in whom gastro-intestinal and upper respiratory symptoms failed to respond to therapy and operations until replacement thyroid therapy was given.

The presence of hypothyroidism should be considered as a possible causative factor in a variety of symptoms, especially where no relief is obtained by accepted methods of treatment. It is not necessary to wait until the onset of myxedema before the diagnosis of hypothyroidism is made. Seward [1] recently published a list of symptoms and signs frequently seen in mild hypothyroid states. He concluded that hypothyroidism should be kept in mind when patients complain of the following symptoms: Easy fatigue following mental or physical exertion; mental depression; nervousness, irritability, and insomnia; palpitation on exertion; loss of appetite; gas formation, nausea, and abdominal distension; constipation; vague pains; and susceptibility to pains and infections. Additional symptoms noted are vasomotor rhinitis, dryness of skin, localized edema, headache, menorrhagia, metrorrhagia, and abdominal pains.

Engelbach [2] defines adult myxedema as a "Severe form of thyroid deficiency acquired after maturity. It is associated with aplasia and atrophy of the thyroid gland, with diminished supply of thyroxin to the body cells, resulting in a nuclear hyperplasia and an increased development of the connective tissue, with a mucin infiltration in the subdermal, submucous and other tissues of the body, resulting in anatomic and functional alterations in nearly all systems."

The pathology [3] consists of a hypoplasia of the follicular secreting substances, resulting in sparsely placed degenerated epithelial cells, scattered through a marked overgrowth of poorly vascularized connective tissue, producing cirrhosis of the thyroid gland. The influence of thyroxin deficiency in adult life pertains more to decreased cellular activity. In earlier life it is much more serious. During embryonic life there would be a delay of primary tissue differentiation; while during postnatal life there would be a retardation of somatic growth and mental development; and during adolescence there would be abnormal genital function.

The diagnosis of myxedema is rarely made if the basal metabolic rate is not at least minus thirty per cent; but mild hypothyroid states may be diagnosed in rates below fifteen per cent. Usually the myxedematous patient is a heavy individual, slow in action and speech, with a low guttural pitch of the voice. The skin is dry, thick, and inelastic. The hair is fine and silky, while the nails are thin and brittle. The patient has a mask-like expression, with an alabaster color of his skin simulating pernicious anemia. The eye-lids and lips are usually puffed out. There is a loss of muscle tone, a, diminished production of heat, and a tendency to subnormal temperature. Sterility is not uncommon and was also present in the author's case.

Means [4] states that the nervous system reaction is that of a marked reduction in irritability and reactivity of (a) the central nervous system as shown, for example, in the diminished perception of sounds, impaired memory and diminished reflexes, and (b) the autonomic nervous system, as manifested in lessened

secretory and involuntary motor function, such as peristalsis and cardiac action.

The most important clinical sign is the *lowered basal metabolic rate;* while the most important biochemical sign is the *increased blood cholesterol.* Calcium and phosphorus may be found to be deposited in greater concentration in the bones. Cardiac dilatation or "myxedema heart" is a frequent finding. The most conclusive sign is the reaction of the patient to replacement therapy. As will be shown in the author's patient, the reaction to specific therapy is usually so marked that the entire appearance of the patient is altered enough to present a father and son, or a mother and daughter appearance of the before and after photographs.

The etiology of myxedema is still in a rather debatable stage, as there appears to be a division of opinion between an infectious origin (Plummer) and an iodine deficiency state (Marine).

The differential diagnosis when considering myxedema would require the elimination of cardiac disease, nephrosis, nephritis, pernicious anemia, exogenous obesity, gastro-intestinal diseases, and encephalitis because of the somnolence.

The author's patient presented mainly gastro-intestinal and upper respiratory symptoms. He had a submucous resection for nasal obstruction without relief, a hemorrhoidectomy, and many gastro-intestinal and gall-bladder roentgen-rays. Hinton [5] found hypothyroidism to be a cause of abdominal pain in a small group of patients in whom the roentgen-ray examination and other laboratory procedures showed no evidences of pathological changes in the gastro-intestinal tract, the gall-bladder, or the urinary system. Brown [6] regarded mild hypothyroidsim as a factor in the causation of chronic constipation of middle life, particularly in women of the obese type who have a lowered metabolic rate.

CASE REPORT

C. M., a fifty-four-year-old white man, a blacksmith, was first seen by me professionally in the spring of 1933. As he was an employee in the Home for several years prior to 1933, I had noticed his failing state of health. I knew that he was being treated for gall-bladder disease by a specialist, and that he was on a diet. The yellow color of the skin, plus the history, suggested to me a possible malignancy of the liver, or a neoplasm involving the gall-bladder. I also noted that he was dyspneic, drowsy, and easily fatigued.

I was called to see him in 1933 because of bleeding following a tooth extraction. The bleeding was stopped by packing the cavity. This contact gave me an opportunity to examine him thoroughly. In appearance he was markedly stooped, looked heavy and dull. His skin was icteric and edematous. The teeth were in bad condition with many caps. The tonsils were small, and did not appear septic. The neck showed no thyroid enlargement. The heart was enlarged to the left, and the sounds were regular with no murmurs. The lungs were normal. The abdomen was distended, and ascites was not demonstrated. The liver was somewhat enlarged and not tender to touch, although he had complained of occasional pain over this area.



A B

A.—Patient in March, 1933, before Treatment Was Started.

B.—Patient in March, 1935, Two Years after Replacement Therapy.

Neurological examination was negative, and psychiatrically he was normal except for his drowsiness. His skin was dry, inelastic and the pubic and auxillary hair was sparse; the speech thick and guttural. Extremities were normal except for oedema of both lower extremities. His chief complaint was occasional pain over the liver area, constipation and gas.

Ten years ago the patient had a hemorrhoidectomy. Following this, constipation rapidly developed and has continued. Two or three years ago he developed abdominal distension associated with passage of much flatus by rectum. He had no abdominal pain or belching at this time. Gall-bladder and gastro-intestinal studies were made, but the reports were indefinite, suggesting a possible duodenal ulcer (no history elicited) and a sluggish colon.

Treatment consisted of diet rich in vegetables and fruits, and administration of laxatives, princi-

pally cascara, taken nightly, with an occasional supplemental purge with one of the salines.

For the past two years he has noted increase in size of his abdomen, much more pronounced recently, when he was told it was due to "ascites". There never was an abdominal pain, but merely discomfort caused by distension,—a feeling of pressure which prevents him from bending over. His stools are at first well formed, but are followed by liquid or very soft semi-solid masses and much flatus. There are no melena or clay-colored stools, and no recurrence of hemorrhoids, but several tabs itch occasionally. Appetite is fair, but this represents no deviation from his normal. No nausea. Coffee, but no other foods, will produce vomiting. Eggs, cabbage, and baked beans produce gas and are therefore avoided. Other foods agree with him. He has no post-prandial pain, in fact he feels much better for several hours following a meal. No jaundice although skin has been sallow and "unhealthy" in appearance for approximately one year. Itching of hands and legs has developed, and his skin feels dry. No gall-stone colic. Slight upper quadrant discomfort.

Weight has been stationary until he has gained ten pounds in the past six weeks (now 190). For some time he has had marked weakness and easy fatigue, although he has continued doing heavy work. Drowsiness has been noted. No reversal of sleep. No thirst, chills, or night sweats. Loss of hair, especially axillary, noted.

There has been bilateral progressive deafness with tinnitus. No pain or discharge from ears. Visual acuity diminishing. No pain, lacrimation, or photophobia. Orbital edema for one year, worse in mornings.

There has been some slight nasal discharge and bilateral obstruction to breathing which was partially relieved by submucous resection. No sneezing or hay fever. No epistaxis since operation. No change in sense of smell. No sinusitis. He had complete dental x-rays taken three months ago, followed by extraction of two abscessed teeth. Moderate bleeding followed. No other history of bleeding. No petechiae or purpuric spots. Coagulation time normal at the time. No sore throat. Sense of taste normal. Not aware of hoarseness or change of speech (but sister noted this). Vague pain beginning over thoracic vertebra extending up into neck. No stiffness, paralysis or limitation of motion. Neck has increased in size. Morning cough with production of thick greenish sputum, especially when he has acute upper respiratory infection. No hemoptysis. Vague soreness in right chest but no pleuritic pain. Fainted once three months ago. Dizziness upon arising suddenly. No palpitation or precordial pain. Dyspnoea on exertion for one year. Bilateral ankle edema—worse on right—not entirely disappearing on rest for two weeks. Occasionally nocturia; otherwise G. U. negative. Hands and feet become cold easily. Has difficulty in keeping warm during winter months. Hands have become swollen recently; also face, ankles, neck. No arthritic symptoms. No disturbance of sensation for one year. (Muscles of lower extremities tire easily when walking and there is some pain. Immediate relief after short rest.)

He had pneumonia and typhoid fever when a young man. Right lung said to be weak since. Hemorrhoidectomy ten years ago. Submucous resection with partial relief of obstruction. Removal of pterygium of right eye following kick by mule. No rheumatic fever, scarlet fever or diphtheria.

Family History.—Mother and father living and well. Six brothers and sisters of patient are living and well. A grandfather died of carcinoma of the jaw. No history of tuberculosis, cardiorenal, allergic or mental disease in family. No other member of family ever had any metabolic disease. Patient married and has lived twenty-seven years with his present wife. No children resulted from this mating.

At the time of the initial contact with the patient it was found that he had a normal bleeding and clotting time. Two urinalyses were normal. The blood count showed a mild secondary anemia. The patient was persuaded to accompany the author to the University of Pennsylvania where he was seen by Dr. T. Greer Miller, Clinical Professor of Medicine, in consultation. Dr. Miller's diagnosis of myxedema was confirmed by the basal metabolic test.

In March, 1933, his basal metabolic rate was minus forty per cent, and he was given dessicated thyroid gland six grains daily. A week later his basal metabolic rate was minus twenty-seven per cent. The dose was increased to nine grains and a week later his basal metabolic rate was minus sixteen per cent. At this time the patient became weak and fainted whenever he tried to stand up. He developed cardiac pains typical of angina pectoris. Dr. E. M. Sickles, of Lakewood, was called into consultation and electrocardiographic studies were made. His heart function was found to be within normal limits and his pains were relieved by small doses of nitroglycerin.

Dr. Edward Rose, Endocrinologist to the University of Pennsylvania, was called into consultation, and the thyroid extract was replaced by *thyroxin*. The dose of the latter drug varied betwen 0.4 to 0.8 milligrams (1/150 to 1/75 grain) daily and has so continued until today, and will continue indefinitely.

The results of the thyroxin treatment has been satisfactory. The basal metabolic rate, in weekly determinations, was found to be minus thirteen, and minus six, and remained at approximately this figure during the past two years. Over a period of months his weakness progressively disappeared, and he gained strength so that he returned to his work as a blacksmith about one year after the onset of the thyroid therapy. During the past six months he has been doing the heaviest kind of work.

The patient's weight dropped from 190 pounds to 155 pounds. This weight loss was mainly due to the elimination of the myxedema. His hearing improved, the constipation was markedly relieved, and the nasal congestion entirely disappeared. The patient became more alert, and for the first time in years he sweated during the summer months. As a result of this his skin became softer; and because of the thyroid replacement therapy the yellowish color of his skin disappeared. He no longer has tenderness over his gall-bladder area.

Thyroxin is the crystallized active principle of the thyroid gland, and is given either intravenously or by mouth, one milligram being equal to one-half a grain of dessicated thyroid gland. It is available in the form of tablets. When it is used by mouth, the best method is to give it with a glass of water containing half a teaspoonful of sodium bicarbonate.

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TUBERCULOSIS CAVITIES, THEIR PATHOGENESIS, MECHANISM, AND TREATMENT

By POL N. CORYLLOS, M.D.,

Professor of Thoracic Surgery, Cornell University Medical School, New York City

Abstract of a paper read before the Atlantic County Medical Society, March 8, 1935. Abstracted by Robert A. Kilduffe, Reporter for the Society.

Prefacing his remarks by a brief resumé of the importance of developing an effective method of treatment for cavitation in tuberculosis, Dr. Coryllos illustrated the complexities of the subject by numerous slides showing various types of cavities and attempts to treat them both by pneumothorax and by thoracoplasty, the results of which were by no means consistent.

An essential prerequisite to a rational treatment was a better understanding of the mechanism of tuberculous cavitation, and particularly of the mechanism of the processes leading to closure.

Dr. Coryllos illustrated his theory by three diagrams of cavities, one in which bronchial or bronchiolar drainage was *free* and unobstructed; one in which it was *partially* obstructed by narrowing of the bronchial or bronchiolar lumen as a result of bronchial inflammatory thickening and edema; and one in which, as an aftermath of an inflammatory reaction, the bronchial or bronchiolar lumen was *totally* blocked and obliterated.

Gaseous analysis of the contents of the acini showed definite differences under these conditions. In the first, the proportions of oxygen and carbon dioxide were practically those of the atmosphere; in the second, as a result of oxygen absorption and carbon dioxide retention of varying degree, a plus-minus pressure obtained often leading to an increase in the size of the cavity; in the third, carbon dioxide predominated, with a negative pressure, resulting in cavity collapse and obliteration.

This concept very naturally linked itself to the studies made on the respiration of the tubercle bacillus, which has been shown to be a strict aerobe. Deprived of oxygen to a partial degree in the second type of cavity, and entirely in the third type, its activity on the tissues was hindered or entirely prevented, thus making reparative reactions more easy and effective.

While these conclusions were borne out by Dr. Coryllos' experimental and clinical studies, obliteration of bronchi or bronchioles draining a tuberculous cavity was seldom feasible for obvious and apparent reasons. It had been tried by numerous workers using various methods, bronchoscopy among them, but without success.

Dr. Coryllos then discussed the relative merits of pneumothorax and thoracoplasty, emphasizing that each had its definite indications and contraindications as well as dangers. Something more than the ability to inject air into the pleural cavity was needed for the intelligent and safe application of pneumothorax. How much to inject, how often, and *when* to use pneumothorax, and especially in which type of case it should be used, were all matters of great and essential importance, requiring skill, judgment, and experience. This was equally true of thoracoplasty.

After showing slides showing the various steps of open thoracoplasty, Dr. Coryllos showed a moving picture of the operation of packing the pleural space with sterile paraffin after partial separation of the pleura.

In closing, Dr. Coryllos commented on the necessity for bacteriological studies in order to detect the presence of anerobes, and thus avoid a possible anerobic infection.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

The Welfare Committee of The Medical Society of New Jersey met on Sunday, October 20, 1935, in Room 404, at 137 East State Street, Trenton, N. J., and was called to order at 2:30 p. m. by Dr. Thomas B. Lee, Chairman.

A roll-call by Secretary Wilkes showed the following members present: Drs. Lee, Morrison, H. Alexander, S. Alexander, Burritt, Coleman, Costello, Curtis, Field, Green, Haggerty, Hoffman, Lewis, Morris, Pollak, Read, Spencer, Stokes, Ulmer and VanNess; and Dr. Wilkes, Secretary.

There were also present Drs. Belting and Satchwell, representing the Board of Medical Examiners, and Dr. R. P. Fischelis, Secretary of the State Board of Pharmacy.

On the motion of Dr. Ulmer, Dr. Hilton S. Read, Atlantic City, was unanimously elected Chairman.

REPORT OF SUB-COMMITTEE ON WORKMEN'S COMPENSATION

The report of Dr. David A. Kraker, Chairman of the Sub-Committee on Workmen's Compensation, was read by the Secretary. Dr. Kraker outlined the policy of the committee to consult Mr. Toohey, State Labor Commissioner, in proposing amendments to the Labor Law, and to support the legislative bills of the Commissioner rather than introduce new legislation in the name of the Medical Society.

The report of Dr. Kraker was approved.

COMMITTEE ON A UNIFORM MEDICAL PRACTICE ACT

Dr. Samuel Alexander, Chairman of the Sub-Committee on a Uniform Medical Practice Act, reported the draft of a bill which is ready for introduction in the Legislature. The bill is intended to provide that after a few years a uniform course of education and training shall be required of all who would practice any system of treatment. The legal point was brought out that an amendment to the present Medical Practice Act would leave intact all the court decisions and interpretations that have been made; while the enactment of a new law might vitiate the court decisions already made concerning the present law.

The members of the Welfare Committee felt that the Sub-Committee had clearly stated a practical basis on which physicians, osteopaths, and chiropractors would agree; but that the implications and ramifications of the law should be studied carefully. A motion was therefore made and carried that the report of the committee should be accepted with thanks, and that a new committee should be appointed to consider all aspects of the proposed bill, especially those of a legal and social nature. Dr. VanNess stated his opinion that the present Sub-Committee should be represented on the new committee.

SPECIAL COMMITTEE ON PUBLIC HEALTH

In the absence of the Chairman, Dr. Stanley H. Nichols, the Secretary of the Committee on Public Health, Dr. Wilkes, gave a brief report on its activities. He first presented five charts showing statistics on the Public Health Hour, developed with the coöperation of the State Department of Health, to whom reports are made by physicians coöperating in the Hour.

The Secretary emphasized the necessity of an extensive plan of publicity to include both the medical profession and the lay health agencies, especially the Parent-Teacher Associations, who have been acive promotors of antidiphtheria and smallpox immunizations. He exhibited a series of lantern slides which contained an outline of an explanation of methods to be followed in promoting the Public Health Hour, and including also a description of the methods followed by The Medical Society of New Jersey in carrying on its work. Dr. Wilkes also demonstrated a hand projector which could be used in showing the slides during the lecture.

The Secretary also gave a brief description of the American Academy of Pediatrics, the New Jersey branch of which is anxious to integrate its work, through its state members, with that of the Public Health Committees in County and State Societies. A project is under way to form a Public Health Council which will integrate the programs of workers in tuberculosis, cancer, maternal welfare, and mental hygiene, with those of other organizations participating in public health work.

On motion of Dr. Ulmer, the report of the Public Health Committee was accepted.

EASTERN INTERSTATE MEDICAL ECONOMICS CONFERENCE

A report of the Conference of the Medical Economics Committees of the Eastern States was given by Dr. T. K. Lewis. A brief, with specific recommendations, had been presented by Dr. Lewis at this Conference; and as a result, New Jersey was asked to send a copy of the recommendations of Dr. Lewis to each State Society and Territorial Society in the United States, and to each of the Trustees of the American Medical Association. (For description of the Conference, see page 660.)

SOCIAL SECURITY

Secretary Wilkes gave a report on the Milwaukee meeting of the American Public Health Association which he attended on October 7-10. Dr. Wilkes was Chairman of the Section on Child Hygiene, and presented the program of The Medical Society of New Jersey in a symposium on Community Care for the Child. The Association speakers had emphasized the provisions of the Federal Security Law, agreeing that the ways and means of carrying out the provisions of the law would be determined by each State.

LEROY A. WILKES,
Secretary.

HEARING ON THE SOCIAL SECURITY ACT

The Governor's conference to consider the provisions of the Federal Social Security Act held a public hearing on October 7, 1935, at 10 o'clock a. m. in the Assembly Chamber, Trenton, for the purpose of hearing anyone who had suggestions regarding the scope of and method of work of the conference. Dr. Henry L. Derby, chairman of the conference, presided, and stated that the conference wished to receive answers to several questions, such as:

1. What are the needs under the several subdivisions of the act?

2. What are the present facilities for dealing with the conditions?

3. What additional facilities should the State provide?

4. What changes in the laws of New Jersey are necessary in order to provide for the needs and at the same time conform to the provisions of the Federal Security Act?

The conference also wished to give opponents of the Security Act an opportunity to express their views. There did not seem to be any opposition to the act itself, although there will doubtless be many opportunities for legal complications in hurried attempts to comply with the Federal requirements.

Dr. Thomas K. Lewis represented The Medical Society of New Jersey at the hearing and gave a general description of the nature of the medical services which would be needed under the Security Act, as follows.

ADDRESS OF DR. LEWIS

The Medical Society of New Jersey wishes to express its appreciation for this opportunity of appearing before the Social Security Commission of New Jersey and desires to indicate its eagerness and willingness to cooperate with that commission in the consideration of its activities insofar as the activities have to do with the care of the sick and the physically handicapped.

The Medical Society of New Jersey would call attention to the fact that it is in a position to understand, beyond the capacity of any other agency, the medical needs of the people of New Jersey. Such suggestions and recommendations as hereinafter follow result from the accumulated experience of many years in administering to the medical needs of the under-privileged classes and are submitted with two chief objects in view:

1. The proper and economic use of such public monies as shall be allocated to the care of the sick or the rehabilitation of those with physical handicaps.

2. The proper coördination of all agencies included in the Social Security program that have to do with the practice of medicine for effective administration of the needed medical service.

Those activities included in the Social Security program impinging upon the practice of medicine are as follows:

Old Age Benefits.
Dependent Children.
Crippled Children.
Maternal and Child Welfare.
Public Health.
Vocational Rehabilitation.

OLD AGE ASSISTANCE PLANS

Under this section no provision is made for any kind of medical service. As the result of past contact with patients who are recipients of widows' pension, already in existence in New Jersey, many cases have been found where the individuals not only have been unable to pay the physician but also have been unable to purchase medicine, proper food, or other accessories (belts, trusses, eye glasses, etc.) essential to health and physical comfort.

Therefore in the use of any additional public funds for the aged, it would seem wise and essential to set aside monies for supplementary aid to those who require drugs, special foods, and special surgical or medical appliances. The designation of such needs should be established through medical agencies.

AID TO NEEDY DEPENDENT CHILDREN

In this section of the act no reference is made to the medical care of such children. Provision should be made for medical care, medical accessories, and special foods (such as extra milk and cod-liver oil, etc.)

Under the Board of Children's Guardians, this work is well established in New Jersey. However, by means of closer contact with the medical profession in an advisory capacity more adequate care of the physical needs of these children could be secured.

SERVICES FOR CRIPPLED CHILDREN

This section specifically provides for "medical, surgical, correction and other services and care and facilities for diagnosis, hospitalization and after care for children who are crippled." In its Crippled Children's Commission, New Jersey has an agency already functioning and accomplishing a useful work. More definite control by the medical profession of the kind and quality of care accorded these children is much to be desired. Specifically the surgeons and hospitals caring for the crippled children should measure up to certain definitely established standards of professional and technical efficiency.

In this section of the act no specifications are made as to the economic status of the recipients of benefits under the Crippled Children's service. It would seem essential that the use of public funds should be conserved for the treatment and care of those children whose families are incapable of financing the necessary medical attention.

MATERNAL AND CHILD WELFARE

This section covers a service which is almost purely medical. In view of the fact that the State Medical Society and most of the component County Societies have committees devoted to this proposition, it is recommended that this service be turned over to these existing organizations under the administration and direction of the State Board of Health.

PUBLIC HEALTH WORK

The State Medical Society of New Jersey is well satisfied with the high standard of accomplishment that has been attained by the State Health Department. It is suggested that the additional Federal funds allotted to this work might well be used in support of the "Public Health Hour" program now in existence, fostered by the State Medical Society, as an effective means of stimulating the education of the profession and laity alike along the lines of preventive medicine.

VOCATIONAL REHABILITATION

Work in this department has been in existence in New Jersey by way of the Rehabilitation Clinics for the past 18 years. Many physically handicapped young people have been trained for occupations or professions suitable to their physical capabilities, thereby rendering them self-supporting. With added Federal funds, the scope of this work could be broadened to include many who are handicapped by medical ailments such as Tb. and Heart Disease. It is our belief that closer coöperation with the medical profession and a better coördination of this service with other agencies would add much to the efficiency of this work.

EASTERN INTERSTATE MEDICAL ECONOMICS CONFERENCE

A meeting of the Eastern Interstate Economics Conference was held on October 13, 1935, in the Hotel Lexington, New York City. This Conference had been organized on January 27, 1935, in Atlantic City, as described in The Journal of February, 1935, page 106. The present meeting was attended by thirty-six representatives from seven component organizations of the American Medical Association —District of Columbia, Indiana, Maryland, Michigan, New Jersey, New York and Pennsylvania. Other members of the Conference are Connecticut, Delaware, Maine, Massachusetts, New Hampshire, Ohio, Rhode Island, Vermont and West Virginia, but none sent representatives.

The New Jersey representatives were: Drs. Eagleton, Snedecor, Quigley, Herrman, Ulmer, Lewis, Wood, Wilson and Wilkes.

Dr. Frederick E. Elliott, of Brooklyn, Chairman of the Economics Committee of the Medical Society of the State of New York, presided as President of the organization. The Secretary is Dr. Francis F. Borzell, of Philadelphia.

The delegations of the District of Columbia and New Jersey were the only ones that had been officially appointed and empowered to act in the name of their societies. Dr. Thomas K. Lewis read a concise statement of the attitude of The Medical Society of New Jersey, ending with a suggestion that the Conference propose to the Trustees of the A. M. A. that it call a special meeting of the House of Delegates to discuss economic problems. This suggestion was unanimously adopted by the Conference.

The address of Dr. Lewis follows:

ADDRESS OF DR. LEWIS

We have the greatest admiration for the achievements of the Bureau of Economics of the American Medical Association in its exhaustive study of every phase of Medical Economics, and we wish to express our deep feeling of appreciation for the definite and unequivocal stand taken by the House of Delegates at its extraordinary session held in Chicago last February. However, with every indication of a renewed and more insistent drive on Washington, during the coming legislative period, for the adoption of some form of compulsory health insurance, and in view of continued propagandizing of the American people by various socialistic groups, it would seem urgently necessary for organized medicine in the United States to assume a more positive and aggressive rôle in medical leadership.

It is a fact that the widely published and well-advertised pronouncement of the House of Delegates of the A. M. A. at its February meeting stands out in the minds of the public as the one major utterance of the American Medical Association, with the result that there has grown the belief that the physicians of the Country are obstructionists and selfish reactionaries. This erroneous impression cannot be corrected by a policy of watchful waiting, but only by widespread public dissemination of correct information as to the true status of medical philosophy.

The A. M. A. Bureau of Economics has accumulated an enormous amount of valuable data. The imperfections in present methods of distributions of medical service are well understood. Readjustments are vitally necessary if we would stave off socialization of medicine. The time has come when the profession has the right to look to the American Medical Association to lead the way out. It is freely admitted that no intricately detailed plan, suitable to the peculiar needs of every community, can be produced. However, general policies and broad principles of procedure can be outlined and fostered on a nation-wide basis.

We, therefore, submit the following recommendations:

1. That the American Medical Association formulate and state clearly its understanding of the need for a readjustment in the method of distribution of medical service to fit the changed social conditions; and that this understanding of the situation be given the widest possible publicity.

2. That the stand taken by the House of Delegates with regard to compulsory health insurance be reiterated, and full exposition of the reasons for that stand be made known to the public.

3. That the American Medical Association under the guidance of a publicity committee or a publicity manager, enter upon an intensive educational campaign for the purpose of giving the people of the United States a clear understanding of the many problems involved in medical economics.

4. That the American Medical Association be urged to assume leadership in outlining a detailed plan of action, or a method of procedure, by which a better means of distribution of medical service, particularly for the low wage classes, can be provided. In accomplishing this objective the basic principles of the *Washington plan* are strongly recommended, namely:

a. Control of the distribution of all forms of medical service by the Medical Profession, through county, regional, or municipal units of organized medicine.

b. Adequate socio-economic investigation of all applicants for charitable or modified medical service not only for the purpose of safeguarding the profession, but for protection of public funds from misuse by individuals and agencies capable of self financing.

c. The arrangement of modified fees on a

basis fair both to the donor and recipient of such medical service.

d. The provision of facilities which will make possible the payment of medical services on the installment plan after the obligation has been incurred.

Additional matters which call for united action under the leadership of the American Medical Association are as follows:

1. The urgent need for supplementary Emergency Relief for the families of W. P. A. workers where wages are insufficient to meet the basic needs of the family.

2. The desirability of continuing the medical care of the destitute under some such plan as that of Medical Emergency Relief now in successful operation in the State of New Jersey.

3. *Standardization of Hospitalization Insurance* plans, with emphasis upon the discouragement of hospitals from entering into the corporate practice of medicine, and upon the perpetuation of the hospital as an institution whose function is to furnish *facilities for* the practice of medicine.

At the time of the annual convention of the American Medical Association the scientific program dominates the picture, and the House of Delegates is so burdened with a vast amount of routine business that but scant attention is given to the consideration of these vital economic problems. Accordingly the question is submitted for consideration by this Interstate Conference: "Whether or not it would be wise to urge the calling of a special meeting of the House of Delegates of the American Medical Association, in the near future, for serious consideration of the whole economic problem."

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

A meeting of the *Conference of Allied Medical Professions* was held on Wednesday, October 23rd, 1935, at 137 East State Street, Trenton, New Jersey, at 2:30 p. m. Those present were: Dr. Fischelis, presiding; Drs. Haggerty, Wilkes, Owens, Miss Seifert and Miss Ashmun.

The meeting was called to discuss primarily the Social Security Act and the various W. P. A. projects formulated by the constituent societies in the Conference.

Dr. Wilkes spoke of Dr. Lewis' committee report before the New Jersey Social Security Commission, and stated that the chief concern of the medical profession at present relates to the old age and dependent children sections. There is no provision made in the budget for payment for medical service as a single phase of relief in the so-called Social Security Act as passed by Congress.

Miss Seifert spoke of the aim to provide more "generalized" nursing programs through the State, and showed three maps which indicated:

1. The distribution of the limited amount of bedside nursing now available in New Jersey;

2. The distribution of the work of the Child Hygiene Division under Dr. Levy; and

3. The school nursing services.

In many cases these services overlap and are often rendered by the same person. Yet, there are areas not covered by any of the three types of nursing.

Miss Seifert stated that the Public Health Nursing group is anxious to see the nursing services of this State generalized and supervised by a director of nursing in the State Department of Health. She said she understood that the medical profession was opposed to this; and she and Dr. Wilkes had a lengthy discussion as to the scope of functions of the "social worker", the "public health nurse", and other persons who might be interested in helping as a "good neighbor" in the solution of difficulties of one kind or another as they arose within the family. The others present joined in this general discussion.

Dr. Owens explained the "school dental project" conducted under the E. R. A., and mentioned a supplementary project to take care of the dental needs of the children placed out under the "home division" of the Board of Children's Guardians.

Dr. Fischelis did not mention any specific project in which the pharmacists were especially interested.

There seemed to be a general consensus of opinion that there was inadequate available information as to the plans of the Federal government which are to govern approval for the State program as devised to meet local needs and conditions. The meeting adjourned at 5 p. m.

D. Leo Haggerty, M.D.,
Secretary.

STANDING ORDERS FOR NURSING CARE

The report of the Committee on Nursing and Nursing Education given to the House of Delegates on April 30, 1935, by its Chairman, Dr. H. H. Satchwell, contained a section entitled "Policies Adopted by The Medical Society of New Jersey and the State Organization for Public Health Nursing", in two parts, "A. Standing Orders for Nursing Care", and "B. General Policies in Regard to Health Education". This report was approved by the House of Delegates; and was printed in the Transactions of 1935, pages 33 and 63.

The report was then submitted to the Board of Medical Examiners of New Jersey in order to get its opinion regarding the scope of the nurse's duties in giving first aid advice and treatment. The following form of the Standing Orders and Policies has been approved by the Board of Medical Examiners, and accepted by the Committee on Nursing and Nursing Education:

POLICIES ADOPTED BY THE STATE MEDICAL SOCIETY OF NEW JERSEY AND THE STATE ORGANIZATION FOR PUBLIC HEALTH NURSING

A. STANDING ORDERS FOR NURSING CARE

Standing Orders may be used in an emergency until a physician can be secured or in the absence of orders from the attending physician.

The nurse may not carry out verbal orders given through the family, unless verified by the physician.

For New Patients

Urge the calling of a physician if none is in attendance.

General care as to the situation requires the nurse to instruct the family in hygiene of the sick-room and care of the patient until next visit.

General care includes: bath, care of bed and making the patient comfortable.

For Elevated Temperature—Adults

Have a physician called if none is in attendance.
Put patient to bed.

Urge importance of rest and quiet.

General isolation routine if communicable disease is suspected.

Liquid diet and plenty of water.

Sponge for rectal temperature of 102.5 or over.

If patient is suffering from abdominal pain, nothing shall be given. Call a physician.

Infants and Children with Elevated Temperature

Urge calling a physician.

Put to bed. Isolate.

No enema shall be given unless ordered by a physician.

For Infantile Convulsions

Have a doctor called immediately.
Hot bath with gentle friction of skin.
Ice cap on head.
Discontinue all feeding.

Burns

If burn is severe and no physician can be reached, remove patient to hospital. If burn is not extensive, remove clothing, if not attached to skin.

If clothing is adherent, do not disturb. Free portion of clothing may be cut away.

Call physician.

Earache

No treatment. Call doctor.

Discharging Ears

Urge prompt medical attention.

Cleanse outer ear with swabs dipped in boric acid solution.

Do not irrigate.

Dressings—Minor Wounds

Urge medical attention.

Cover with sterile gauze. No treatment.

Sore Throat and Colds

Urge medical attention.

Isolation.

Plenty of water.

Liquid diet until doctor is on case.

Ulcers

General medical care.
Urge medical attention.
No other treatment.

Suspicious Communicable Diseases

Isolate.
Boric acid solution for eyes.
Vaseline or cold cream for lips and nose.
Liquid diet.
Sponge for rectal temperature of 102.5.
Call physician.

Obstetrical Cases

In obstetrical cases the following procedures are recommended by The Medical Society of New Jersey:

The written approval of the individual physician must be obtained before these procedures are carried out with his patients.

For Expectant Mothers

Urge medical care.

See "Health Education—Prenatal and Postnatal Instructions", in Section B.

Apply bandages to varicose veins.

Maternity corset if necessary.

Report to the physician any unfavorable symptoms.

Preparation for Delivery

General preparation of home supplies and equipment for delivery (bed, dressings, etc.).

Low enema at beginning of labor.

Clip hair from pubis.

External cleansing of the perineum and surrounding area.

For the Mother After Delivery

Cleansing bath.

Local dressing and external cleansing with one-half per cent lysol solution.

And such other orders as physician shall prescribe.

For the Baby

Sterile dressing to the cord.

Oil and bathe.

Keep warm.

Post Partum Hemorrhage

Send for physician.

Elevate foot of bed.

Put patient in elevated Sim's position.

Keep patient quiet and warm.

B. GENERAL POLICIES IN REGARD TO HEALTH EDUCATION

Health education of adults and children in the home, the school, in industry and in special group conferences is a legitimate part of the nurse's work. She urges competent medical and dental care, and assists in seeing that the instructions and treatment ordered are carried out.

General Health Instruction

As part of her regular duties in clinical bedside care in the home, the nurse has an opportunity to instruct the members of the family concerning procedures for their care when sick; the prevention or dissemination of disease; and the general rules for the maintenance of health. In so doing, she should neither diagnose nor treat.

The nurse should reinforce the medical or dental opinion given, and should strive to obtain such opinion from the family doctor when not already given.

Hygiene—General Advice

Instruction under this term should include:

General advice as to fresh air, rest, sleep and exercise, nutrition, cleanliness, recreation and regularity in these things.

Diet in infant feeding and in specific adult diseases may be regulated under the supervision of a physician.

Prenatal and Postnatal Instruction

The nurse should urge regular medical and dental care and supervision for pre-natal patients from their first suspicion of pregnancy.

Instruction in the hygiene of pregnancy.

Instruction in the preparation for delivery.

Urge post-partum examination at the time indicated by the physician.

Infant and Pre-School

The nurse should urge continued medical supervision of all children especially those up to two years of age.

Detection of Defects and Symptoms of Disease

The nurse should urge medical examination for suspected physical defects (sight, hearing, defective teeth, enlarged glands, malnutrition, faulty posture and others). Her advice must emphasize the necessity of obtaining medical and dental advice on these maters. This advice having been obtained she should stress the importance of having the defects corrected. She should stress the importance of early diagnosis and continued adequate treatment.

COMMUNICABLE DISEASE PREVENTION

Nurses may give the following advice in regard to:

Smallpox

Vaccination of infants by a physician before the end of the first year.

Diphtheria

She should stress the desirability of immunization at six months of age, or as soon thereafter, as practicable, by a physician or under his direction. She should advise a Schick test six months after the immunization procedure in order to determine whether the immunity has been established.

Typhoid Fever

Urge medical advice regarding inoculation for travelers, vacationists, and those living in the family of a case or carrier.

Isolation

She should coöperate with the Department of Health. She should stress the necessity of the household observing the quarantine regulations; and select the person who is to take care of the patient and teach her the technic of isolation for the particular disease and environment.

October 21, 1935.

NEW JERSEY TUBERCULOSIS LEAGUE

The twenty-ninth annual meeting of the New Jersey Tuberculosis League, of which Dr. J. B. Morrison, of Newark, is President, was held on Friday, October 25, 1935, in the Stacy-Trent Hotel, Trenton. Over 150 members and representatives were present including a goodly number of physicians and of officials of The Medical Society of New Jersey and the State Department of Health.

The League is the official representative of the American Tuberculosis Association in New Jersey, and is the agent for the sale of Christmas Seal Stamps, and for the distribution of the leaflet entitled "Tuberculosis Abstracts" which is distributed monthly as a supplement to The Journal of The Medical Society of New Jersey, and to many other State Journals. It supports a campaign of popular education on the subject of tuberculosis, and conducts demonstrations methods of detecting tuberculosis, especially in children.

The program was devoted largely to methods of discovering cases of tuberculosis in their incipiency, with special emphasis on testing school children by means of tuberculin injections and the use of the x-ray. Outlines of the addresses of the speakers had been prepared for distribution to the press and journals of the State. The trends of the discussions are indicated in the following abstracts.

Mr. Ernest D. Easton, Executive Secretary, gave a report, in which he said:

"According to the American Public Health Association's standards, most of our counties show good ratings as to the number of visits to the clinics and home visits by the nurses. Most of the counties have fairly adequate accommodations for patients, which is now one bed or more per death. Additional facilities will soon be available in Middlesex, Hudson and Essex Counties. Most of the institutions are using all the modern facilities available, such as pneumothorax, thoracoplasty, phrenicectomy, etc. Most of them either have laboratory facilities or access to them.

"We must, however, be constantly on the alert to find new ways of making people 'tuberculosis conscious'. For this reason I wonder if we should not give more consideration to the mass x-raying of school and factory groups. In a recent test on the first 600 applications for the C. C. C. Camp at Camp Dix, eight open cases were found and recommended for hospitalization. Many other suspicious cases were also located and are being watched. If this plan could be used for larger groups and the open cases isolated, no doubt we could have a more complete control of all infection."

Dr. Charles I. Silk, Clinician, Middlesex County, and Vice-President of the League, gave an address on "Standardization of Case-finding Procedure in Public Schools". He said:

"The main object in subjecting large groups of people to the tuberculin test and x-ray examination of the chest is, first, to find open tuberculosis in its communicable stage so as to shut off at their source the fountains of infection; second, to find some cases in the minimal stage that they may be more readily cured, and so prevented from becoming hopelessly advanced; third, to find the borderline cases that they may be warned of impending danger and given proper advice; and fourth, that the reactor may lead to the discovery of familial or other sources of infection. Some appropriate legislation along these lines seems highly desirable.

"The scene of action as well as the subjects of our study being the school, school personnel, and school children, it seems right and proper that the school authorities be the sponsors for the tuberculosis case-finding program, stimulated and guided by the tuberculosis league or the tuberculosis division of the board of health or sanatorium. The consents for the examinations must be obtained through the authority of the school, and it must assume the responsibility of informing the parents or guardians of the results and the necessity of after-care. All cases requiring medical attention should be referred to the family physician, and when indigent to the clinic.

"The x-ray examination can be considered satisfactory with either paper, celluloid film or fluoroscope, the competence and experience of the interpreter and the technician being the all-important factor. Only physicians trained in tuberculosis work, with a broad view of the tuberculosis problem, are qualified to conduct tuberculosis case-finding projects in schools. These are entitled to reasonable compensation."

Dr. W. L. Weintraub, Clinician, Valley View Sanatorium, spoke on the subject "What to Do with Reactors", saying:

"A recently completed survey which concerns itself with 1046 children who reacted to one-tenth milligrams of old tuberculin administered intradermally, and who had been under observation for periods varying from six months to five years, presents data and suggests conclusions which may be of considerable interest to public health officials who find themselves responsible for their local tuberculosis programs. Observation on 547 children with definite *contact* histories recorded eleven instances of breakdown to adult-type of pulmonary tuberculosis; whereas similar observations on 499 *non-contacts* yielded not a single such instance.

"It would appear from a public health standpoint, bearing in mind that the tax monies must at all times be so expended as to yield the best return possible, that the routine following-up and periodic x-raying of large numbers of non-contact tuber-

culin positive children of the pre-school and pre-adolescent age groups are not justifiable considering a study of the results obtained: i. e., the number of cases of adult type of pulmonary tuberculosis discovered. The tuberculin testing of such groups to obtain the tuberculinization rate of the community is exempted from the above, involving very little expenditure, with the avowed purpose not being case finding but rather the readily obtainable *reactor incidence*. This may be a very valuable check upon the success of any particular program when comparisons are made at later dates with similarly tested groups.

"Tuberculin testing, with the x-raying of reactors and re-x-raying at intervals, should be advocated in private practice much more extensively than at present; and if offered to the public in the proper light, it should not prove very difficult to enlist the support of those financially able to carry on such personal health investigations, and to have them appreciate their value, if only from the viewpoint that, for small sums expended periodically, assurance can be given that clinically significant pulmonary tuberculosis is not present in a particular child."

Paul T. Stafford, Ph.D., of Princeton University and the Princeton Survey Commission, addressed the Conference on the subject "The Need of Larger Health Units in the Fight Against Tuberculosis", saying:

"Rural health administration to meet current needs must be placed upon a county-wide or regional basis, under the direction of a full-time, competent health personnel, fully protected against partisan political influence. The movement for county health units originated in Yakima County, Washington, in 1911, and has since spread rapidly throughout the country, greatest progress being made in the Southern States.

"So far New Jersey has not joined the movement for full-time county health organization, but there are many who believe that the time has come when definite action can and should be taken. This belief has recently been encouraged by the publication of the results of a health survey in Morris County. Conducted by competent and impartial experts, this survey strongly urges the establishment of rural public health services upon a county-wide basis in this state. The development of improved local health organization in New Jersey may proceed along two lines. In the first place, state legislation may be secured which would authorize the individual counties to create full-time county health units. In the second place, a County Public Health Council may be formed with representatives from the various health agencies in the county.

"The Princeton Local Government Survey has been established for the purpose of studying problems of local government in New Jersey, and devising methods for their more effective treatment. The problem of local health administration will be an important concern in these studies; and it is hoped that proposals can be advanced for the better planning and execution of local health functions."

These extracts indicate the general trend of the discussions and the procedures that are advocated by the League.

All the former officers of the League were reëlected for the coming year.

See editorial comments on page 626.

THE ASSOCIATION OF MILITARY SURGEONS

THE NEW JERSEY CHAPTER

Receipt of the Charter from National Headquarters marks the establishment of *The New Jersey Chapter* of The Association of Military Surgeons of the United States, culminating the efforts of Major Albert G. Hulett, Med. Res., U. S. Army, of East Orange, New Jersey, who serves as Secretary-protempore of the Chapter.

Associated with Major Hulett as Founder Members of the Chapter are Lieut. Col. David B. Allman, M.C., U. S. N. R., of Atlantic City; Lieut. Col. George A. Enion, M.C., N. G. N. J., of Trenton; Col. David A. Kraker, Med. Res., U. S. A., of Newark; Col. John H. McCullough, M.C., N. G. N. J., of Trenton; Lieut. Leonard S. Morvay, ex-Dental Corps, U. S. A., of Newark; Major Clyde R. Newell, San. Res., U. S. A., of Hackensack; Lieut. Frank Overton, Aux. Med. Res., U. S. A., of Trenton; Lieut. Col. Harry Subin, Med. Res., U. S. A., of Atlantic City; Major Albert W. Sweet, San. Res., U. S. A., of Freehold, New Jersey; First Lieut. W. K. Van Arsdale, Med. Adm. Res., U. S. A., of South Orange, and Lieut. Col. Ray C. Meals, Med. Res., U. S. A., Veterans' Facility, Lyons.

Each of these founder members will be recognized as prominent in medical and patriotic activities for many years past, and all performed distinguished service in the late war. The enrollment of Charter Members is now proceeding, and is open to all present or past officers in the Medical Departments of the Army, Navy, Marine Corps, U. S. Public Health Service, and Veterans Administration, and the Reserve Corps of each.

Some thirty charter members have been elected to date, and the number should reach fifty before the enrollment period expires. With regard for the number of eligibles within our State, Major Hulett states that the roster

of New Jersey Chapter should grow rapidly and eventually exceed two hundred Medical Service Officers.

The address of the Chapter is the office of the Secretary at 20 Hawthorne Avenue, East Orange, New Jersey.

THE NATIONAL ORGANIZATION

The Annual Meeting of The Association of Military Surgeons of the United States witnessed the unanimous election to the Fifth Vice-Presidency of Colonel Harold B. Corbusier, Medical Reserve Corps, United States Army, of Plainfield, New Jersey, following his unanimous selection as the candidate of the Reserve Component of the Association at a caucus presided over by Major Albert G. Hulett, Medical Reserve Corps, U. S. Army, of East Orange, and the concurrence therein of the Nominating Committee of the Association.

This election, which places Colonel Corbusier in direct line for advancement to the Presidency of this important patriotic body, comes as an acknowledgement and reward for long-continued and distinguished medical service in the Army and in promoting the cause of national security in civil life.

Colonel Corbusier saw service in the China Relief Expedition, the Phillipine Campaign, the Mexican Border action and pursuit of Villa, and in the World War; in addition to which he served also in the U. S. Marine Hospital Service, the National Guard, and the Organized Reserves, and has been responsible for several pioneering researches regarding foot disabilities of the soldiers of our Army, the reconstruction of disabilities, and other important matters which have earned him the commendation of the War Department.

Albert G. Hulett,
Secretary Pro tem.

AN EARLY EXPERIMENT IN TRANSFUSION

Dr. Aims R. Chamberlain, of Maplewood, has sent us the following quotation from the diary of Samuel Pepys, under date of November 14, 1666:

"At the meeting at Gresham College tonight, which it seems they now have every Wednesday again, there was a pretty experiment of the blood of one dog let out, till he died, into the body of another on one side, while all his own run out on the other side. The first died upon the place, and the other very well and likely to do well. This did give occasion to many pretty wishes, as of the blood of a Quaker to be let into an Archbishop, and such like; but may if it takes be of mighty use to man's health, for the mending of bad blood by borrowing from a better body."

Mr. Pepys evidently supposed that the blood of the recipient dog consisted almost entirely of the donor; but in reality it was probably only about one-fourth. When about one-half of the blood has run out of the donor's body, the heart action will be too weak to force more into the veins of the recipient. Then too, the recipient will constantly lose the blood of the donor as well as its own. The result would be that at the end of the experiment somewhere about one-third or one-fourth of the blood of the recipient would be that derived from the donor.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE BIOLOGICALS SINCE JULY 1, 1935

DIPHTHERIA TOXOID

County	To Sept. 30	Month of October	Total to Oct. 31	Average per Month
Atlantic	38	15	53	13.2
Bergen	379	176	555	138.7
Burlington	44	5	49	12.2
Camden	75	22	97	24.2
Cape May	92	19	111	27.7
Cumberland	272	30	302	75.5
Essex	960	385	1345	336.2
Gloucester	69	19	88	22.
Hudson	2	5	7	1.7
Hunterdon	1	0	1	.2
Mercer	26	22	48	12.
Middlesex	167	48	215	53.7
Monmouth	58	14	72	18.
Morris	176	29	205	51.2
Ocean	5	0	5	1.2
Passaic	595	222	817	204.2
Salem	19	41	60	15.
Somerset	60	5	65	16.2
Sussex	0	2	2	.5
Union	491	293	784	196.
Warren	95	14	109	27.2
Totals	3624	1366	4990	1247.5

SMALLPOX VACCINE

County	To Sept. 30	Month of October	Total to Oct. 31	Average per Month
Atlantic	63	25	88	22.
Bergen	216	163	379	94.7
Burlington	120	31	151	37.7
Camden	167	122	289	72.2
Cape May	100	39	139	34.7
Cumberland	315	34	349	87.2
Essex	700	449	1149	287.2
Gloucester	248	93	341	85.2
Hudson	1	1	2	.5
Hunterdon	10	5	15	3.7
Mercer	27	29	56	14.
Middlesex	316	105	421	105.2
Monmouth	18	32	50	12.5
Morris	386	119	505	126.2
Ocean	13	0	13	3.2
Passaic	917	348	1265	316.2
Salem	70	46	116	36.
Somerset	101	15	116	36.
Sussex	4	1	5	1.2
Union	1015	521	1536	384.
Warren	207	10	217	54.2
Totals	5014	2188	7202	1800.5

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

NOVEMBER

5	Camden	14	Essex
6	Hudson	14	Passaic
8	Atlantic	20	Middlesex
12	Bergen	21	Gloucester
13	Mercer	27	Monmouth
13	Ocean		Sussex
14	Burlington		

DECEMBER

3	Camden	12	Passaic
3	Hudson	12	Somerset
10	Bergen	13	Atlantic
11	Mercer	13	Salem
11	Ocean	18	Middlesex
11	Union	19	Gloucester
12	Burlington	19	Morris
12	Essex	25	Monmouth

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held October 11th, at the President Hotel, the President, Dr. C. C. Charlton presiding. There were 50 members present.

Minutes of the May meeting were read and accepted.

A letter of thanks was read from Mrs. Newcomb, and also from Mrs. Senseman, for flowers sent to Dr. Newcomb and Dr. Senseman.

An announcement of a meeting of the Eastern Interstate Medical Economics Conference to be held in New York on October 13th was read, and a motion passed that Dr. H. S. Read should represent this Society at that meeting.

The application for membership of W. W. Hersohn, M.D., was referred to the Board of Censors for their action.

Reporting for the *Library Committee* Dr. Darnall said new books were still being purchased.

Dr. Kaighn reporting for the *Broadcasting Committee* said that Dr. Read has the programs arranged up to December.

The *Entertainment Committee* report by Dr. Subin stated that the Annual Outing had been conducted to the enjoyment of the members, and thanked Drs. Uzzel, Mason and Davidson for the use of Dox Folly.

Dr. R. A. Kilduffe reporting for the *Publication Committee* urged all the members to send in all items of interest for the Bulletin.

MEDICAL RELIEF

Dr. Darnall reporting for the *Medical Advisory Committee* stated that he had been notified that the W.P.A. projects that are being started do not come under the E.R.A. and bills and complaints should be sent to the W.P.A. headquarters where they will be taken care of by the U. S. Compensation Commission.

Dr. Darnall gave some interesting figures showing how much the E.R.A. has paid to the medical and dental professions in this County since the beginning of 1935. The total amount is approximately $80,000, and Dr. Darnall stated that most of this work would have been done as charity if the E.R.A. had not taken care of it.

HEALTH MEETING

Dr. Carrington announced that the National Health Council was interested in promoting a town meeting for the discussion of health problems. The Chamber of Commerce will arrange a dinner meeting if the medical profession will furnish the program. Dr. Charlton appointed a Committee comprised of Drs. Carrington, Harvey and Salasin to meet with the Program Committee and the Chamber of Commerce to arrange this meeting.

RADIO ADVERTISING

Dr. Carrington also presented the following resolution which was unanimously adopted by the Society and copies ordered sent to the City Commissioners:

Whereas, Radio Station W.P.G. is advertising patent medicines whose sponsors are making false and fraudulent claims to the public,

And Whereas, this practice is detrimental to public health,

And Whereas, this radio station is supported by the taxpayers of Atlantic City of which the medical profession is an integral part:

Therefore, Be It Resolved, by the Atlantic County Medical Society that this Society petitions the City Commissioners to discontinue patent medicine advertising over Station W.P.G. as soon as the present contracts expire.

DUES

Dr. Allman, Treasurer, requested that the dues for 1936 be announced earlier than in previous years as the State Assessment must be paid by February 1st, and when the Society dues are not billed until December this does not give the members sufficient time to get their checks to the Treasurer. At Dr. Allman's suggestion a motion was passed that the dues for 1936 be $16.00. These dues may be paid anytime before December 31st, 1935.

INFLUX OF OUTSIDE PHYSICIANS

Dr. Rosenblatt said he thought some action should be taken, if possible, by the Society to prevent the influx of out-of-town physicians who arrive in the summer season from taking a large proportion of practice away from local physicians.

Dr. Harvey stated that if anyone could prove these physicians were not licensed to practice medicine in this state and would furnish this evidence in writing, the matter would be properly taken care of.

AUTOMOBILE INSIGNIA

Dr. Allman said it was possible that the physicians in Atlantic City would not be furnished with the usual identification for their cars in 1936, and suggested that the Society should take some measure to provide these so that the police would know when a car belonged to one of our members and would not put tags on or tow it away. Dr. Charlton announced that he would appoint a committee to wait on the Mayor to find out if he intended to issue cards. If he does not, the committee will arrange suitable identifying signs.

SCIENTIFIC

The scientific program was presented by a group composed of members of the Atlantic County Medical Society and comprised a review of the medical activities of this county.

The program was opened by Dr. Robert A. Kilduffe, Director of Laboratories of the Atlantic City Hospital, who described the functions and operation of the Tumor Clinic which was started in the hospital one year ago.

"The Newer Trends in Surgery" was the subject of an address by Dr. David B. Allman, who discussed, particularly, changes in the surgical management of fractures of the skull, the newer methods of treatment of osteomyelitis, and the present treatment of extensive burns.

The *medical activities* were to have been discussed by Dr. D. Ward Scanlon who was, however, unable to be present because of illness in his family.

Dr. Clyde M. Fish presented an interesting review of the newer methods applied to the treatment of *tuberculosis,* which, he said, was very definitely becoming a surgical problem. He emphasized the excellent results which are now being obtained in appropriate cases through the intelligent use of pneumothorax and thoricoplasty.

Dr. E. H. Harvey presented Dr. S. L. Salasin's review of the *public health* problems as they confront the physicians in this county.

The papers were followed by a general but brief discussion.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Hackensack Hospital on October 8th. The minutes of the September meeting were read and approved.

The Executive Committee minutes were approved as printed in the Bulletin.

NEW MEMBERS

The following were elected to membership:

From Junior to Regular—
Dr. Charles A. Abbate, Lodi
Dr. G. Barton Barlow, Englewood
Dr. Mark E. Branon, Rutherford
Dr. D. J. Calabrese, Rochelle Park
Dr. Louis C. Cartnick, Wo dridge
Dr. C. Clarie, Ridgewood
Dr. Mark M. Kroll, Cresskill
Dr. Norman Van Sant Myers, Glen Rock

To Regular—
Dr. Ernesto Iannuzzi, Grantwood

To Associate—
Dr. Samuel A. Sandler, Hackensack

To Junior—
Dr. Anthony M. Romano, Hillsdale

The following applications for membership were read:

For Junior—
Dr. V. De Biaso, Rutherford
Dr. Robert J. Neville, Hackensack

From Junior to Regular—
Dr. Rubin Grossman, Garfield
Dr. Frank S. White, Teaneck

For Regular—
Dr. Joseph Latona, Lodi

Communication: A letter from Mrs. Marcus W. Newcomb thanking the Bergen County Medical Society for the flowers which were sent to Dr. Newcomb while he was sick.

INSURANCE

Mr. W. Blanksteen, representing the National Casualty Company, told us about the advantages of an accident and health policy with an Insurance Company that has the approval of The Medical Society of New Jersey. He also warned the doctors not to take insurance from "fly by night" or other Insurance Company that was not carefully investigated.

ANNUAL BANQUET

Dr. Walter J. Farr announced that the Annual Banquet would be held at the Swiss Chalet on Thursday evening, November 21st. The Banquet is to be a testimonial to Dr. E. E. Conover, who has been in active practice for fifty years.

POST-GRADUATE COURSE

Dr. David Corn brought up the subject of the Post-Graduate Course for this year. After much discussion Dr. F. S. Hallett moved that a course be given on November 8th sponsored by their Society. This motion was passed.

SCIENTIFIC

Mr. A. Granito, President of the Bergen County Pharmaceutical Association, was introduced by our President. He spoke upon the Minstrel Show to be given on November 8th which was being sponsored by the Lions Club.

The meeting was then turned over to Dr. David Goldberg, who had arranged an excellent symposium on "Eye Diseases". The speakers were ophthalmologists who are members of our own County Society.

Dr. Charles Littwin and Dr. S. T. Hubbard presented excellent paper on "Photophobia and Am-

blyopia", and "The Problem of Strabismus in Children", emphasizing the importance of recognizing the disturbances of vision and of having every child with strabismus refracted.

Dr. R. N. Burke spoke upon the "Fundus in Relation to General Medicine". He showed beautiful colored slides which demonstrated the fundus changes in simple arteriosclerosis, hypertension, nephritis, diabetes, pernicious anemia, leukemia, polycythemia, syphilis, alcohol and tobacco poisoning, and others.

Dr. Arcangelo Liva spoke on "Oculist vs. Optometrist". He brought out the fact that 35 per cent of the people who went to oculists or optometrists to be examined for glasses either did not need glasses or had some disturbance of vision which needed medical care.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

Members of the *Cumberland County Medical Society* were the guests of Dr. Reba Lloyd at her country home, Ivy Manor, on October 8. There was considerable comment that this would be an ideal place for the proposed County Tuberculosis Sanatorium. The President, Dr. S. D. Bennett, being absent, Dr. B. H. Walker, Vice-President, presided.

An encouraging letter was received from Mrs. Newcomb stating that Dr. Marcus W. Newcomb, President of the State Medical Society, who underwent a serious operation of appendicitis in the Mount Holly Hospital, was convalescing.

Dr. Sydney L. Segal, of Millville, was proposed for membership through transfer from the Hudson County Medical Society.

A report on the Physicians' Lien Law stated that it was operating well.

TIME OF ANNUAL ELECTION

Amendments to the Society's constitution were proposed, one making five meetings a year of the Society, instead of four; the other making the annual election of officers of the Society in April instead of October, to conform to the State Medical Society. The April meeting will be held in Newcomb Hospital, Vineland.

NEW OFFICERS

The election of officers resulted in the choice of Dr. Burton H. Walker for President; Dr. L. E. Myatt for Vice-President; Dr. H. H. Wilson, Treasurer; Dr. E. S. Corson, Reporter; Delegate to the State Society, Dr. H. G. Miller; Alternate, Dr. L. E. Myatt.

E. R. A.

There was an open discussion of economic subjects pertinent to the welfare of the public and doctors. Dr. L. E. Myatt, Chairman of the E. R. A. Welfare Committee, reported on the pros and cons of the workings of the medical phase of the E. R. A. work, and heard the complaints and suggestions of those present.

A resolution expressing the thanks of the Society to the Bergen County Medical Society for its pioneer efforts to adjust the working of the E. R. A. rules to medical practice was passed.

The April meeting will be held in Newcomb Hospital, Vineland.

TUBERCULOSIS CLINICS

In discussion of the tuberculosis clinic, it was stated many persons presented themselves for examination without the recommendation of a physician, thereby overcrowding the clinic. It was voted to recommend that no person be examined by the clinic doctor unless accompanied by a doctor or a note stating the reasons for sending the person for examination.

Dr. Charles Butcher, of the County Health Association, stated that any complaints or criticism of the agents of the association should be submitted to him for investigation and before so doing adverse decision should be withheld.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The *Essex County Medical Society* held its 120th Annual Meeting Thursday evening, October 10, 1935, at the Academy of Medicine, Newark, with President John F. Condon presiding. The 400 members who attended showed the most interest in the local application of the "Washington Plan", and in an expression of opinion about the proposed new Newark City Hospital.

ADOPTION OF THE "WASHINGTON PLAN"

The Economics Committee, James H. Lowrey, Chairman, had conducted the preliminary investigation of the Washington Plan, and in its report, had advised the Society to adopt it (pages 576, 618, 622). During the discussion Dr. S. M. Rubinow offered well considered suggestions, as follows:

"The resolution on the floor, recommended for acceptance by the Council, involves two issues.

"1. It asks the members to give their approval to the entire Washington Plan.

"2. It asks for an affirmative vote in the matter of instituting the Medico-Dental Service Bureau.

"I am ready to vote 'yes' on the second issue on the organization of the Medico-Dental Service Bureau for the following reasons:

"While I do not expect that this Bureau will be of much good to the general practitioner, to the family doctor, I recognize that it may help some physicians: the surgeons, the obstetricians, the dentists, some specialists, in those cases where more or less large fees are involved and where there are no close relations between doctors and patients. And I believe that any measure which may help even some of the physicians and dentists should be welcomed at times as trying to the professions as they are at present. Moreover, this Bureau will function on a voluntary basis. The doctor may or may not send his patient to the Bureau. The patient may or may not go there. For these reasons I am ready to vote yes on the question of instituting the Medico-Dental Service Bureau, and will watch with interest its workings.

"But one hesitates to vote his approval of the entire Washington Plan, as presented to us, for the following considerations: Admitting that the Washington scheme will eliminate certain abuses in the

clinics and hospitals on the part of a group of patients, the so-called chiselers; admitting that it will save some money in the management of the hospitals and welfare organizations by squeezing out a few dollars from the semi-indigent and low income groups, which constitute more than 80 per cent of our people; admitting all that and recognizing the many shortcomings of the present system, one nevertheless does not believe that these merits of the plan justify an imposition of hardships on the thousands unfortunate but decent citizens who will have to undergo a complete financial investigation any time they are compelled to seek medical advice. One visualizes the loss of time and the physical and mental strain involved in having first to go to the clearing house to get a permit for a clinic admittance and having to answer innumerable questions concerning every detail of their domestic life. Such a scheme is against the best traditions of our profession; such a scheme will not be good-naturedly accepted by the American people and will surely react unfavorably on the relations between the community and the professions once it will be known that this scheme was instituted by the doctors.

"The short single experience in Washington is not sufficient to convince one of the truth of all the statements made on this platform by its sponsor, Dr. Ross Garrett. I have not seen any references or recommendations of this plan in the medico-economic literature. As far as I know, the A. M. A. has not expressed its opinion on the plan, and one wishes to sound a warning to the Essex County members not to be too hasty in giving its approval to this plan.

"I would like to make a motion that separate votes should be taken on the two issues—One, on the approval of the plan; and another on the organization of the Medico-Dental Service Bureau."

This motion was not seconded.

The society approved the local establishment of an organization similar to the one operated by the physicians and dentists in Washington, D. C.

THE PROPOSED NEWARK CITY HOSPITAL

The proposed building of a new twenty-one-story City Hospital in Newark was discussed after it was reported by Dr. S. W. Ebenfeld that the Medical Staff of St. Michael's Hospital had the previous day unanimously condemned the City Hospital building program. There was a preliminary discussion whether the subject of a new Newark City Hospital was a proper subject for consideration by the County Medical Society.

Dr. John F. Hagerty ably pointed out that the County Society should properly consider every subject of importance to the interests of its members and that this subject was particularly pertinent to the physicians' welfare.

Dr. E. Zeh Hawkes told the Society that it was the consensus of opinion among the City Hospital Staff that the building as planned was so large it would be a menace to other hospitals. He added that Dr. Clarence O'Crowley, head of the City Hospital Staff, had appolnetd a committee of doctors to confer with City Commissioner Franklin with a view of protecting the private institutions. Members of the committee were selected because of their connection with private hospitals. They were, in addition to Dr. E. Zeh Hawkes, who acted as chairman, Drs. Wells P. Eagleton, Harry Epstein, John F. Condon, R. H. Dieffenbach, F. A. Alling and J. H. Lowrey. They adopted the following opinion and submitted it to the Commissioner: "It is the sense of this meeting that the building that is now contemplated is too large for the indigent sick of the City of Newark; and while we are in favor of a fire-proof building adequate for the needs of the indigent sick, we are opposed to the plans as now proposed, feeling that the hospital would be capable of too great expansion and may become a menace to the hospitals and the doctors of the community. We also go on record as limiting the admissions to the City Hospital to the indigent sick of the City of Newark."

After the committee's talk with Commissioner Franklin, the architect was directed to redraft his plans and submit them to the committee. A change to reduce the maximum bed capacity from 1100 to 850 was ordered. Laboratories which had not been planned for the new building will be included in the revised plans to account for the space made available by the reduced bed capacity. There also will be drawn a hospital charter designed to limit the use of the hospital to the indigent sick.

The change in plans will not mean any alteration of the size of the building as planned, but will mean a rearrangement of the use of the rooms. It is Commissioner Franklin's opinion that a charter, drawn by the hospital staff and approved by the City Law Department, should be adopted by the City Commission. He said the charter could be incorporated in an ordinance. There is no City Hospital charter at present. Through the charter, Franklin hopes to assure the medical profession and those controlling private hospitals that the new institution will be restricted to use by the indigent, and will not compete with private hospitals.

After this explanation and further discussion by many, the County Medical Society went on record opposed to a new Newark City Hospital.

Dr. John F. Condon delivered his presidential address and made a profound impression on the audience. It contained four well considered and valued recommendations to the Society. On motion of Dr. Eagleton, the Society voted to create a committee to consider Dr. Condon's recommendations.

ELECTION OF OFFICERS

The following officers were elected:
President, A. Charles Zehnder.
First Vice-President, Edgar A. Ill.
Second Vice-President, H. Roy Van Ness.
Secretary, Frank W. Pinneo.
Treasurer, Robert H. Rogers.
Reporter, Earl LeRoy Wood.

For Councilors: Eugene W. Erler, J. Irving Fort, Walter B. Mount, John T. English.

For Nominating Committee of the State Medical

Society: Alfred Stahl, Member; Walter B. Mount, Alternate.

For Delegates to the State Society (three years, till 1938): W. H. Areson, Richard N. Connolly, Harry B. Epstein, J. Irving Fort, William F. Grady, John W. Gray, Paul H. Hosp, Sidney C. Keller, David A. Kraker, James H. Lowrey, Paul E. Menk, Walter B. Mount, Raymond J. Mullin, Arthur Pilch, C. F. Rathgeber, Charles Rich, Alfred Stahl, Francis C. Weber, Earl LeRoy Wood. Alternates: Charles W. Barkhorn, Samuel H. Baldwin, Kenneth Blanchard, Gustave Braun, Fletcher F. Carman, A. R. Chamberlain, Charles G. Crane, Eugene W. Erler, A. J. Ganley, Alan O. Godfrey, W. T. Gutowski, E. C. Klein, Jr.; Otto G. Matheke, Harold A. Murray, Anthony Parisi, A. Russell Sherman, H. H. Satchwell, R. W. Walton, Arthur W. Wyker.

Alternates (one year, till 1936): John E. Toye, William H. A. Warner, Asher Yaguda.

NEW MEMBERS

The following were elected members:

Regular—James F. Foley, East Orange; Kenneth E. Gardner, Bloomfield; Samuel B. Greenwood, Newark; Leslie C. Love, Montclair; K. Verginia Maurer, Livingston; Herman P. Miller, Newark; John J. Moriarity, Montclair; Daniel Leslie Rothschild, Newark; Paul Slavin. Newark; Edward H. Taylor, Maplewood; Gennaro L. Tomasulo, Newark; Michael Yankowicz, Newark.

Associate—Pascal J. Baiocchi, Newark; Martin Becker, East Orange; Jacob Bleiberg, Newark; Donald Marion Caldwell, Newark; Richard R. Chamberlain, Maplewood; Charles H. Cornish, Maplewood; Camillo Joseph Ferri, Newark; Joseph Gamba, Newark; A. Leslie Gibbins, Newark; Theodore Lawrence Greenwald, West Orange; Abraham R. Heller, Kearny; Paul Franz Hennig, Irvington; Jacob Heyman, Newark; Thomas Campbell Hooton, Montclair; Herman Insel, Newark; Bernard D. Lifland, Newark; Walter E. Longshore, Jr., Orange; Samuel Pecora, Newark; Charles H. Reinacher, Newark; Samuel Morton Weterman, Newark.

NECROLOGY

The Necrology Committee presented its report of the deaths of members of the Society in the form of an "In Memoriam" booklet containing short sketches of the lives of the following: James Spencer Brown, Clarence V. Bumsted, Albert Frey, William M. Goodwin, Chauncy B. Griffiths, Harry Blatt Harris, James Starr Hewson, William F. Hoeler, Max Lionel Ignatoff, Myer L. Levin, Boris N. Margulis, Floy McEwen, Albert Burr Nash, Henry Thomas Obuchowski, George B. Philhower, Robert Potter, Watson F. L. Rodeman, Henry Woodbridge Thayer, Russell E. Titman, James Harry Trainor, William H. Van Giesen, Albert Victor Widman.

DUES

Robert H. Rogers, Treasurer, recommended that the County Society dues for the next year be seventeen dollars, which amount will be apportioned as follows: $13 to the State Society; $3 retained for the County Society; $1 to the Relief Fund.

HOSPITAL COMMITTEE

The annual reports of all committees were received. In Dr. Sprague's report of the Hospital Committee, the following general principles and recommendations were offered:

1. The general question of adequate medical care for the indigent was considered. The principles stated that Essex County must have adequate clinics for the indigent; and the findings were that Essex County has adequate clinics for the indigent.

2. The following most important declaration was developed: "That it is the right and duty of the medical profession to determine for itself what individuals, institutions and organizations have a claim upon physicians for gratuitous services."

3. We recommend the establishment of advisory officers from the Medical Staff to work jointly with the Social Service and Executive Departments of the hospital on the question of admissions for gratuitous services. This has been done in all institutions.

4. Pay clinics. Recommendations were made that the average and usual clinic may charge a nominal sum, approximately twenty-five cents. A special clinic may charge for cost of material or services rendered.

5. We recommended that a card be sent to the physician who had referred a patient to a hospital—stating that the patient was leaving the hospital on a given date.

6. We recommended the Medical Staff of each hospital to continue its check-up on staff members as to their County Society membership.

7. We recommended that in hospitals where a fee for the hospital is charged, and a fee for the physician is made, be it ever so small, the physician should send a separate bill.

8. That home confinements be advised only under conditions where satisfactory work could be done in the opinion of the attending physician.

9. We recommended that Social Service Departments in the hospitals be urged to consider the physician in each case. We feel that many cases could be determined as able to pay and could be referred back to the doctor from the hospital.

POST-GRADUATE INSTRUCTION

Dr. H. H. Satchwell for the Post-Graduate Instruction Committee reported five years' progress with future plans for a course in physio-therapy to bring this important work into medical rather than lay hands.

Dr. E. Zeh Hawkes for the Medical Relief Advisory Committee reported, "The State of New Jersey pays the doctors for the E. R. A. care of the indigent about $80,000 a month, of which the County of Essex receives about one-quarter."

ECONOMICS

Dr. Lowrey for the Economics Committee reported:

"We sent out a questionnaire and the first question was: Would you approve of the establishment of a business bureau for the collection of delinquent

accounts under the control of the Essex County Medical Society? Four hundred and ninety-four voted 'yes'; forty-six voted 'no'.

"Do you make use of a collection agency? Two hundred and fifty-three voted 'yes'; 287 voted 'no'.

"Do you recommend any? Ninety-six voted 'yes'; 424 voted 'no'.

"Almost 50 per cent indicated they were using some form of agency; 95 per cent favored a Society controlled business bureau".

MEMBERSHIP

Dr. Charles Rathgeber for the Membership Committee reported a total membership of 923, including those elected at this meeting.

Dr. Van Ness for the Credentials Committee reported thirty-seven Regular and forty-three Associate Members approved during the year.

PRESBYTERIAN HOSPITAL STAFF MEETING

A special meeting of the Medical Staff of the Presbyterian Hospital was held Tuesday, October 15, 1935, to consider the proposed new Newark City Hospital. After much discussion the opinion was endorsed that Newark should have an adequate fire-proof hospital for the care of its indigent sick capable of treating about 750 patients.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The annual social session of the *Gloucester County Medical Society* was held on the evening of October 17th at the Woodbury Country Club, with the physicians entertaining their wives at dinner and with a program of entertainment.

Dr. William Webb, of Nebraska, gave a timely and very interesting address on "Work and Play".

One of the features of the program was the presentation of the annual award for "merit and valor" to Dr. William Pedrick, of Glassboro, who drove to a meeting of the Society last winter in a sleigh. The presentation was made by Dr. C. I. Ulmer, of Gibbstown.

Mr. James G. Morgan, Sr., entertained with "Tricks That Tease", and music was provided during the evening by Robert Taylor's instrumental trio.

Members and their families present were: Dr. and Mrs. Knight, Dr. and Mrs. Hollinshed, Dr. Diverty, Dr. and Mrs. Ashcraft, Dr. and Mrs. Ulmer, Dr. and Mrs. Downs, Dr. Ristine, Dr. and Mrs. Rhoades, Dr. Patterson, Dr. and Mrs. Weems, Dr. Dorothy Rogers, Dr. and Mrs. Brewer and Katherine Brewer, Dr. Sinexon, Dr. and Mrs. Livengood, Dr. and Mrs. Sherman, Dr. and Mrs. Moore, Dr. and Mrs. Lummis, Dr. and Mrs. William Pedrick, Dr. and Mrs. Wright, Dr. and Mrs. Underwood and Dorothy Underwood and Dr. Campbell.

Guests were: Dr. Hiram Webb, Dr. and Mrs. Tracey and Dr. and Mrs. Hornberger, Burlington; Dr. and Mrs. Gamor, Camden; Dr. and Mrs. Miller, Millville; Dr. and Mrs. Kline, Dr. and Mrs. Kinny, Dr. Richardson and Dr. Palm, all of Camden, and Mr. and Mrs. Moore, Swedesboro.

The Society meets again on November 21.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, October 1, 1935, at the Carteret Club, Jersey City, with the President, Dr. E. J. Chapman, in the chair.

ELECTION OF OFFICERS

The following is the result of the election of officers:

President, T. J. Schuck
Vice-President, J. L. Evans
Treasurer, C. B. Kelley
Secretary, T. McG. Brennock
Reporter, J. N. Connell

Board of Trustees (3 years to 1938): W. L. Williamson, E. J. Chapman.

Board of Censors (3 years to 1938): A. M. Zitani.

Audit Committee (3 years to 1938): G. Mangone.

Publication Committee (3 years to 1938):
H. B. Ainsley — J. C. Talty
N. L. Shulman — V. J. Sheeran

Delegate to State Nominating Committee (to serve in 1936): J. F. Londrigan.

Alternate to State Nominating Committee (to serve in 1936): F. J. McLoughlin.

Committee on Constitution and By-Laws (3 years to 1938): S. Kooperstein.

Legislative Committee (3 years to 1938): S. G. Scott, H. Spence, E. J. Connell.

Public Health Committee (3 years to 1938): H. Forman, C. A. Peterson, W. Pindar.

Delegates to State Convention (3 years to 1938):
T. McG. Brennock — J. Nevin
A. W. Justin — W. L. Williamson
G. Sullivan — S. Woodruff
J. F. Norton

To fill unexpired term of Dr. E. Thum, deceased (1 year to 1936): M. I. Marshak.

Alternates to State Convention (3 years to 1938):
W. Maver — D. D. Dougherty
F. Pearlstein — V. Butler
A. Weiss — M. Shapiro
A. P. Rieman

Election Committee (to serve in 1936):
S. G. Scott — W. Doody
W. Eckert — H. J. Perlberg
W. Hammer — G. W. Kerdasha
D. D. Dougherty

Nominating Committee:
J. J. Botti — C. J. Larkey
A. J. Conty — E. J. Daly
W. T. Callery

POST-GRADUATE COMMITTEE REPORT

Dr. Thomas White, Treasurer of the Post-Graduate Committee, submitted a statement of its activities and suggested that a better plan of raising the cost of these lectures be worked out between representatives of the State Post-Graduate Committee and our local committee. He felt that a fund should pay for the cost of the lectures, and that they

should be open to all physicians of the Society, rather than to continue the present plan of soliciting subscriptions and hoping to raise enough money to pay expenses. He said that at the present time there has been no discussion as to the method of paying for next year's lectures, and contact with the State Post-Graduate group should be made in the near future. Dr. White believed that the courses which have been given are worth while continuing, for the lectures were by men who cover their subjects well, and favorable comment has been expressed by those who have attended the lectures.

LEGISLATIVE COMMITTEE REPORT

Dr. B. S. Pollak remarked that all matters that have been reported have received the consideration of his committee, and that the Legislators and the Senator of Hudson County have at all times responded to their requests. Dr. Pollak stated that he had been elected Chairman of the State Legislative Committee and all legislative matters of the State will come to him, and he in turn will report to the Society.

WELFARE COMMITTEE REPORT

The following is Dr. B. S. Pollak's report:

"During the last year, particularly during the last few months, the State has become interested in the *Washington Plan.* It has been adopted in Texas and many other places, and in Washington under the auspices of the Medical Society of the District of Columbia; and in scope and fact goes far in making the lot of the practitioner a happier one. I am of the opinion that the Society should invite these gentlemen from Washington to address us and explain the plan, and also, the Medical Economics Committee be requested to study this plan and report to the Society upon their findings. A similar plan was instituted by the Essex County Medical Society and reported at length in which many of the local societies participated and from what we gathered at the last meeting of the Medical Society, the Essex County Society will put the Washington Plan into effect. (See p. 670.)

E. R. A.

"I have found it encumbent upon myself to attempt to make inquiries concerning welfare conditions affecting physicians in Hudson County relative to the workings of the E. R. A. We are all aware of the fact that on two consecutive occasions, we had voted against the acceptance of the E. R. A. provisions in Hudson County which had become successful in other counties. This had been a great detriment to the physicians of Hudson County, and not long ago we finally accepted a resolution to adopt the provisions of the E. R. A. As a result of this, it was ascertained that certain definite arrangements had been entered into with the E. R. A. by the local E. R. A. Administrator in the personage of the Honorable John F. O'Neill, County Relief Director, and that it has been possible in various communities to effect a working plan which seems to be of advantage to the practitioners of the County outside of the limits of Jersey City. The definite acceptance of the plan becomes effective October first.

"Owing to the fact that Jersey City had no plan for the treatment of its poor and indigent, the County Administrator was obliged to make some provisions for hospital and medical care for the indigent ill of Jersey City. Jersey City is paid a sum of approximately $26,000 per month, which has been supplemented by a smaller sum; and this sum has been devoted to the care and hospitalization of the indigent sick of Jersey City.

"I have interviewed Mayor Hague, and found him favorably inclined toward the adoption of the E. R. A. project in Jersey City. I, therefore, move that a committee be appointed to interview the Mayor so that the physicians who wish may share in the benefits of the E. R. A. service."

This motion was carried, and the committee was appointed, consisting of Drs. B. S. Pollak, L. A. Pyle, E. J. Chapman and John Faison.

Dr. Alonzo Little desired to know what authority the Society had to designate who should do E. R. A. work. Dr. Little stated that every doctor had been doing charity work for a long, long time. Simply because one is on the payroll, he does not see why he should not be paid for the charity work they are doing. Now, our charity patients are turned over to our neighbor doing E. R. A. work.

Dr. E. J. Chapman replied that the State Executive Medical Advisory Committee states that those holding County, State, Federal or Municipal positions must have a two-thirds vote of the County Society in order to be eligible for E. R. A. work. That meeting was held on June 21st, and the vote was lost.

EMERGENCY RELIEF ADMINISTRATION REPORT

Dr. J. L. Evans: "The E. R. A. Medical Advisory Committee of Hudson County has followed the routine procedure for setting up the agreement between the Medical Society of New Jersey and the New Jersey E. R. A. in this county following a communication of September 26th from Mr. John F. O'Neill, E. R. A. Director of Hudson County, in which he stated that the agreement would be put into operation in all of Hudson County on October 1st, 1935, in all the municipalities of the county, with the exception of Jersey City, which is operating under a separate grant.

"We furnished to Mr. O'Neill and all of the Municipal Directors and up-to-date list of all the physicians eligible to treat E. R. A. clients in the county and are supplementing this list as new applicants are placed on the eligible list. Relief orders are being issued to doctors in the various municipalities where the agreement is in operation. We find that, in some municipalities, due to the previous set-up, relief clients who have been approaching the poormasters and who have been sent to town physicians are still continuing this practice, and efforts are being made to have all relief patients seek medical attention through their local Relief Administration offices, and from the contacts that we have made, we feel confident that this practice will be discontinued in all the towns, and that these clients will be sent to physicians who are eligible to give medical attention to relief patients.

"In regard to the City of Jersey City, there has been a committee of local physicians appointed to

devise ways and means of establishing this service in the City of Jersey City and you will, no doubt, receive a separate report of their activities.

"It is also suggested that an equitable situation might be created by establishing a differential whereby all physicians in the county would be placed on a basis by which they could earn a possible income of $3000 a year from governmental practice. For example, a man earning $1500 a year from a governmental medical position would be permitted to work out a differential of $1500 per year from the treatment of relief clients. It is thought this idea is a fair one, and that it would avoid the creation or continuance of two classes of physicians in the County Medical Society.

"Your Medical Advisory Committee has considered the suggestions made and have decided, unanimously, that the idea should again be submitted, in the regular way, to the members of the County Society.

"Our relations with the County Director and the various Municipal Directors have been cordial and your committee is looking forward to the satisfactory operation of the agreement in Hudson County."

Dr. E. J. Chapman: "According to the Executive State Advisory Committee, doctors receiving salaries from governmental positions must have a two-thirds vote of their County Society present at a meeting. That vote was taken last June and they did not receive their two-thirds vote."

MIDDLESEX COUNTY

The Middlesex County Medical Society is sponsoring a Symposium on Endocrinology to be held at the State Homes for Boys, Jamesburg, N. J., on the evening of Wednesday, November 20, 1935, at 8 o'clock. The Society cordially invites all members of The Medical Society of New Jersey to be present.

The program is appended.

HENRY HAYWOOD,
President.

PROGRAM OF THE SYMPOSIUM

Chairman, Max A. Goldzieher, M.D., Brooklyn, N. Y. Author, "Practical Endocrinology", and "The Adrenals". Endocrinologist to the Gouverneur and Brooklyn Women's Hospitals.

1. Disturbances of the Thyroid Gland
   Edward Rose, M. D., Assistant Professor of Clinical Medicine, Medical School, University of Pennsylvania; Chief of Endocrine Section, University Hospital, Philadelphia.

2. The Diagnosis and Treatment of Endocrine Menstrual Disturbances.
   Charles Mazes, M.D., Assistant Professor of Gynecology and Obstetrics, Graduate Medical School, University of Pennsylvania. Gynecologist to the Mt. Sinai and Northern Liberties Hospitals. Author, "Clinical Endocrinology of the Female".

3. Endocrine Disturbances in Children.
   Matthew Molitch, M.D., Resident Physician and Psychiatrist, New Jersey State Home for Boys. Instructor of Neurology, Medical School, University of Pennsylvania.

4. Endocrinology and the Convulsive State.
   A. W. Pigott, M.D., Resident Pathologist, Colony for Epileptics, Skillman, N. J.

5. Papers by Resident Staff of the New Jersey State Home for Boys. Five minutes for each paper.
   A. Laboratory Aids in Diagnosis. Sam Poliakoff, B. Sc.
   B. Dental Abnormalities. J. V. D. Sherlock, D.D.S.
   C. Mental Development and Performance Tests. A. K. Eccles, M.A.
   D. School Achievement and Adjustment. C. Merchant, M.A.
   E. Behavior and Social Adjustment. Philip Repert, B.S.

6. Dr. Goldzieher will discuss the endocrine disturbances, in the adult, not mentioned by either Drs. Rose, Mazer or Pigott.

MONMOUTH COUNTY

James P. Pregnall, M.D., Reporter

The regular meetings of the *Monmouth County Medical Society* were suspended during the summer months. The business of the Society during these months was disposed of by the Executive Committee.

A special meeting of the *Executive Committee* was held on August 19 at the Fitkin Memorial Hospital, with the following men present: Drs. Fairbanks, Gosling, Altschul, Holters, Herrman, Fisher, Prout, and Featherston.

The Secretary was instructed to reply to a letter which was received from Attorney John J. Quinn, Red Bank.

The Treasurer was authorized to send a check to Dr. Harold Kazmann for $42.00, which covered the cost of entertainment for the delegates at the State Convention in Atlantic City.

The Secretary was ordered to submit a list of names of those who have not as yet signed the resolution on hospital clinics, as an effort is being made to dispose of this matter.

The regular meeting of the Executive Committee was held at the Fitkin Memorial Hospital on Monday evening, October 7, at 8:30 o'clock. The following doctors were present: Altschul, Pregnall, Prout, Kazmann, Holters, Hunt, Herrman, Gosling and Featherston.

Dr. W. G. Herrman reported on a meeting of laymen, at which time he spoke on the subject of State Medicine. He expressed surprise at the interest shown and the number of intelligent questions asked by the people. A general discussion followed, and the Secretary was requested to obtain all the

available material possible from the American Medical Association and the State Medical Society with the idea of accumulating a library on the subject.

The LeRoy Press bill of $3.06 for printing was ordered paid.

Secretary ordered to send flowers to Dr. Marcus W. Newcomb, President of The Medical Society of New Jersey, who is convalescing in the Burlington County Hospital, Mount Holly, from an appendectomy.

The State Department of Health advised that a Mrs. Mary Heichemer-Buck, midwife, has applied for a license to conduct a maternity home at Colts Neck, N. J. The home has been inspected and conforms to the requirements of the Health Department. The Secretary was instructed to notify the State Board of Health that the Monmouth County Medical Society had no objection to the granting of a license.

Attention is called to the dramatized radio programs over the Blue Network of the National Broadcasting Company, sponsored by the American Medical Association. These programs can be heard over Station WJZ each Tuesday afternoon at five o'clock.

The October meeting of the *Monmouth County Medical Society* was held in tte Berkeley-Carteret Hotel, Asbury Park, on Wednesday evening, October 23, at 8:30 o'clock.

MATERNAL WELFARE

The report of Executive Committee was accepted, after Dr. Robert A. MacKenzie, a member of the State Maternal Welfare Committee, expressed his disapproval of the action of the Executive Committee in reference to its sanctioning the issuance of a license to a Maternity Home in the County without referring the matter to the County Maternal Welfare Committee. It was moved that in the future all matters pertaining to Maternal Welfare were to be referred to the proper committee before any action was taken. The motion was seconded and passed.

It was moved and seconded that the funds received from the President's Birthday Party be divided and turned over to the two recognized hospitals in the county for use in treating crippled children. The motion was passed.

NEW MEMBERS

Application for membership was received from Dr. George J. McDonnell, Freehold, N. J.

SCIENTIFIC

Following the business session, the meeting was turned over to Dr. R. W. Baeseman, who introduced the speakers of the evening.

"Tumors of the Head and Neck", by Dr. Alfred Hocker, Memorial Hospital, New York City.

Motion Pictures of Ophthalmic Operations, by Dr. Frank Parker, Wills Eye Hospital, Philadelphia, Pa.

MORRIS COUNTY

Marcus A. Curry, Reporter

The Annual Meeting of the *Morris County Medical Society* was held the evening of Thursday, September 26, at The New Jersey State Hospital at Greystone Park, with President McMahon presiding over about forty members.

Routine business included reading and approval of minutes of the previous meeting. The detailed report of the Treasurer, Dr. George J. Young, showing a balance on hand of $1174.16, was approved.

Treasurer Young took occasion to stress the importance of payment of annual dues as soon as possible after the first of the year so that remittance to the State Society could be made for the full membership and thus enable the Society to have its full quota of delegates at the State meeting.

Dr. Edgar J. Evans, of Denville, was proposed for membership.

Unanimous action was taken that the annual dues would continue at $20 for the coming year.

ELECTION OF OFFICERS

Officers for the ensuing year were unanimously elected as follows:

President, William F. Costello, Dover.
Vice-President, Byron G. Sherman, Morristown.
Secretary, Attilio Galasso, Morristown.
Treasurer, George J. Young, Morristown.
Reporter, Marcus A. Curry, Greystone Park.
Historian, L. L. Mial, Morristown.
Delegates to the State Society for two years:
Stanley Teskey, Edward T. Carberry.
Alternates: Dr. Teller, Dr. Spencer.

PRESIDENT'S ADDRESS

The retiring President, B. C. McMahon, gave a very practical talk on the affairs of the Society, emphasizing the following points:

Attending meetings.

The faithfulness of its officers and committeemen.

The value of experience in Society work to younger members.

Competition of cultists, and the need of giving good service to meet it.

SCIENTIFIC PROGRAM

Dr. Lawrence W. Smith, Pathologist at All Souls' Hospital, Morristown, was presented and gave a fine scientific chapter on the subject "Some of the Newer Phases of Poliomyelitis". Having just completed a text book on poliomyelitis as a result of a deep and thorough study of the subject, he was eminently prepared to cover his subject in a masterful and comprehensive manner.

Dr. Smith's paper was discussed by Drs. F. Grendon Reed, Pinckney, Frost, Christian, Coultas, George J. Young, and others.

After adjournment, refreshments were enjoyed in the hospital cafeteria.

Special Meeting

A special meeting of the *Morris County Medical Society* was held at the State Hospital at Greystone Park the evening of Thursday, October 24, 1935. President Costello presided over an assemblage of about 45 members.

DATE OF ANNUAL MEETING

The purpose of the meeting was to vote upon an amendment to the constitution, and the following amendment was adopted unanimously:

"Every meeting shall be a regular meeting and that the annual meeting be changed from September to June, in order to correspond with the fiscal year of the New Jersey State Medical Society."

STATE WELFARE COMMITTEE

President Costello, who with Dr. Frost is a member of the Welfare Committee, reported on a meeting of the committee at Trenton, on October 20, the committee discussed amendments to the Workmen's Compensation Law of benefit to the practitioners in compensation work, and what action to take, whether directly, or through the office of the Commissioner of Labor. There is good contact with the Commissioner of Labor and probably anything attempted will be through him.

A report was made of the work being done on the Uniform Medical Practice Act indicating what is sought to be accomplished will be by amendment to the present Act. This is an important matter, and Dr. Frost didn't think anything done on it would be done hurriedly. The indications are for a busy legislative session this year.

EXECUTIVE COMMITTEE REPORT

President Costello also reviewed the proceedings of the Executive Committee of the County Society; that they thought it would be a good thing if the members of the Welfare Committee were members of the Executive Committee; whereupon the following preliminary action was taken to be published in the notice of the next meeting and acted upon at that meeting: Resolved that the members of the Welfare Committee be ex-officio members of the Executive Committee.

The question of programs for the present year was considered by the Executive Committee, and which brought it before the society in order to obtain any suggestion as to what the programs should be. The question of attendance at meetings also came up and the importance of larger attendance was emphasized as it is not complimentary to guest speakers if meetings be not well attended.

Plans were outlined for the next meeting which is to be an open meeting; and that the intra-county meeting would be continued this year at Morristown Memorial; All Souls at Morristown; Dover General; and at Shonghum, the County Tuberculosis Hospital.

The importance of paying dues before February 1 was stressed so that the society could have a delegation at the State Medical meeting, based upon full membership in the society; also opportunity for increased membership was cited, in the number of physicians in the county who are not members and suggesting key men in various localities to bring in these non-members.

SCIENTIFIC

President Costello introduced Dr. Norman W. Burritt of Summit, New Jersey, as a man who had done a great deal of work on the subject of his talk, which was "Facts Concerning the Pure Food and Drug Legislation." Dr. Burritt gave an interesting resume of his work and of the situation. He was followed by Howard W. Ambruster of Westfield, chemical engineer, who drew interestingly upon about eight years of work and experience in opposing false advertising and the marketing of inert or inferior food and drugs, both at Washington and locally, and championing the present Wiley Law as against the pending Copeland Bill.

After adjournment refreshments were enjoyed in the hospital cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, M. D., Reporter

The Annual Meeting of the *Passaic County Medical Society* was held at the Alexander Hamilton Hotel, Paterson, Friday, October 11, 1935, at 9 p. m., Dr. Wright MacMillan, President, presiding.

The Treasurer's report showed a balance in the treasury of $826.00, and a balance in the sinking fund of $2200.00.

The President introduced Mrs. O'Neill, who was appointed as Assistant Secretary to assist in the official work of the Society.

COUNTY WELFARE HOME

Dr. Leo Becker was introduced by Dr. MacMillan and gave a report of the completion of the Passaic County Welfare Home. He explained that the function of the home would be to care for the chronic indigent sick and incurables. This will fill a long felt want in the county. He also asked that a committee be appointed by the Passaic County Medical Society to meet with a committee of the Welfare Board, to plan for the equipment of the home. Dr. MacMillan then appointed Dr. A. F. McBride and Dr. William Spickers.

NEW MEMBERS

The following members were then unanimously elected to membership:

Dr. Irving Silverman
Dr. Harry G. Rinzler
Dr. Joseph A. Maffongelli
Dr. Louis J. Radest

HOSPITAL PLAN

The Executive Secretary of the "Three Cents a Day Hospital Plan" of New York, Mr. Van Dyke, next gave a talk on the operation of the fund and its advantages to the physicians. This organization, the Associated Hospital Service of New York, is now operating satisfactorily, and many hospitals in New Jersey are coöperating.

ELECTION OF OFFICERS

The following officers were elected:

President: Dr. Norman M. Dingman.
First Vice-President: Dr. Fred Vosburgh.
Second Vice-President: Dr. Louis G. Shapiro.
Secretary: Dr. Wayne W. Hall.
Reporter: Dr. S. W. Johnsen
Treasurer: Dr. Ed. F. Leonard.

Member of the State Nominating Committee: Dr. Wright MacMillan.

Delegates to Annual Meeting of The Medical Society of New Jersey:

Andrew F. McBride	Harry S. Willard
Thomas E. Manley	Samuel Ginsberg
Anthony J. Delario	Charles W. Harreys
John H. Carlisle	Charles J. Murn
Morris Joseph	William M. Sullivan
Wright MacMillan	Harold G. Walker
Elias J. Marsh	William A. Dwyer
John S. Yates	Sandor A. Levinsohn
Lester F. Meloney	

Alternates:

John N. Ryan	Irving Okin
Wayne W. Hall	Fred Vosburg
Sigurd W. Johnsen	Louis G. Shapiro
Robert N. MacGuffie	James R. Lomauro
William Spickers	S. M. Giambra

PHARMACEUTICAL FORMULAE

An announcement was read by Dr. MacMillan from Dr. Loveland, of the New Jersey Pharmaceutical Association, that a number of new formulae were now available to the Medical Profession, and a copy of the same can be secured by writing the Secretary at 28 State Street, Trenton, New Jersey.

SCIENTIFIC

The speaker of the evening, Dr. H. H. Satchwell, Chairman Committee of Hospitals and Medical Education of the State Society, was then introduced. His subject was: "The Washington Plan for Medical Service". Dr. Satchwell gave an excellent talk and described the features of the plan which has been adopted by Essex County beginning January 1, 1936.

A very interesting discussion followed, which lasted until midnight.

INAUGURATION

Dr. Dingman was presented to the members as our next President. He expressed his appreciation for the honor conferred on him, and hoped he would be able to continue the excellent work of his two immediate predecessors in office.

SALEM COUNTY

L. C. Hummell, M.D., Reporter

The regular meeting of the *Salem County Medical Society* was held in the Salem County Memorial Hospital October 10, 1935. This was the first meeting since the summer recess, and the meeting for re-organization.

ELECTION OF OFFICERS

The following officers were elected for the coming year: President, Dr. C. L. Flemming; Vice-President, Dr. J. S. Dunn; Secretary and Treasurer, Dr. D. W. Green; Reporter, Dr. L. C. Hummel; Censors, Drs. James, Hilliard and Hummel.

Delegate to the State Society for three years Dr. D. W. Green; Alternate, Dr. L. C. Hummel.

Nominating Committee, Dr. F. L. Perry.

Delegates to State Society were reëlected without any changes.

SCHOOL PHYSICIANS

Following the business meeting Dr. D. W. Green discussed his work as school physician and gave us a better understanding of what is being done in the course of the regular examinations. He particularly pointed out the increased number of pupils that were being picked up for defective hearing by the audimeter. He also noted a decrease in the number of heart cases over the past few years and suggested it was possibly due to the fact that there had been less rheumatoid disease as a consequence of more tonsillectomies.

DIPHTHERIA IMMUNIZATION

In the course of the discussion diphtheria immunization was again brought up and it was generally conceded that much more had been accomplished by handling the immunization through the school. Another point that was brought out was the fact that the children were required to take physical education as part of their course, but the board of education accepted no responsibility for any injuries incurred during such instructions.

SCIENTIFIC

Dr. J. S. Dunn next presented a case of Pemphigus-Vulgaris which had come to the hospital for a severe Vincent's angina. After the usual local treatments and bismuth injections failed to cause any improvement, neoarsphenamine was given intravenously whereupon the skin lesions became much aggravated while the Vincent's improved. After prolonged treatment the skin condition still remains very little improved.

Dr. L. C. Hummel reported two cases recently treated at the Salem hospital. The first was a case of mechanical obstruction of the ileum due to an appendiceal abscess which had been walled off by two folds of mesentery that had become firmly adherent. The appendicitis was one weeks duration, the patient afebrile, with a leucocytosis of 9,200. The patient recovered in about twenty-four days following the release of adhesions and drainage of the abscess pocket.

The second case was a man aged 81 years with an acute strangulated inguinal hernia. The patient had been suffering from emesis three or four times a day for two years previous to the acute strangulation. At the time of the acute strangulation an attempt was made at reduction with only partial success. Operation under local anesthesia was then resorted to, and it was found the entire descending colon and part of the transverse colon had become adherent in the hernial sac. With the aid of gas anesthesia the bowel was freed and the hernia repaired. The patient has made a satisfactory and uneventful recovery and all vomiting has ceased.

Following the meeting refreshments were served in the hospital dining room.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

Dr. Thomas J. Walsh, of Elizabeth, was elected President of the *Union County Medical Society* at a meeting held on October 9 at Muhlenberg Hospital, Plainfield. Dr. E. S. Krans, of Plainfield, retiring President, was in the chair.

Other officers elected are: Vice-President, Dr. Elmer P. Weigel, Plainfield; Secretary, Dr. Lorrimer Armstrong, Westfield; Treasurer, Dr. Alden R. Hoover, Elizabeth; Reporter, Dr. Russell A. Shirrefs, Elizabeth, and Censor, Dr. N. W. Currie, Plainfield.

Dr. James S. Green, of Elizabeth, was elected to the Board of Trustees; Dr. Watson B. Morris, of Springfield, was named Delegate to the State Nominating Committee, and Dr. E. W. Lance, of Rahway, was elected on the Public Health and Relations Committee. Dr. Alice Gibb, of Elizabeth; Dr. Isaac Gelber, of Union, and Dr. John Tidaback, of Summit, were named on the Committee on Scientific and Literary Work. On the Finance Committee, Dr. Stephen T. Quinn, of Elizabeth; Dr. H. V. Hubbard, of Plainfield, and Dr. G. L. Orton, of Rahway, were appointed.

Annual Delegates to conventions are: Dr. Morris, Dr. Krans, Dr. Walsh, Dr. Herschel Murphy, of Roselle; Dr. Armstrong, Dr. Frederick Lathop, of Plainfield; Dr. Shirrefs and Dr. Emil Stein, of Elizabeth. Alternates are: Dr. J. E. Runnells, of Scotch Plains; Dr. Raphael Tamblin, of Plainfield; Dr. L. G. Beisler, of Hillside; Dr. R. P. Blythe, of Cranford; Dr. C. C. Carpenter, of Summit, and Dr. J. J. Labow, Dr. L. S. Wegryn and Dr. Harry Bloch, of Elizabeth.

The Society voted acceptance of the revised constitution as presented by Dr. Weigel, Chairman of the Constitution Revision Committee.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The annual meeting of the *Warren County Medical Society* was held in Hotel Belvidere, Belvidere, N. J., Tuesday, October 15, 1935, at eleven o'clock.

The meeting was called to order by the President, Dr. Herman Baldauf.

The following members and guests were present: Dr. Herman Baldauf, Dr. G. W. Cummings of Belvidere; Dr. Lawrence Bloom, Dr. Floyd Shimer, Dr. Emory Krausz of Phillipsburg; Dr. William Varney, Dr. J. M. Lemmon, Dr. William Skinner, of Washington; Dr. C. F. Smith of Oxford; Dr. H. B. Bossard of Harmony; Dr. F. W. Curtis of Stewartsville; Dr. James Weres of Alpha.

Dr. Paul Correll, Surgeon in Chief of Easton Hospital and Dr. S. S. Kimmel of Oxford were guests.

The minutes of the last meeting were read and approved.

Drs. Lemmon, Bloom and Smith were appointed a committee to audit the treasurer's report.

NEW MEMBERS

Dr. Wallace R. Bostwick formerly of Morristown, now of Blairstown, was elected a member of Warren County Medical Society by transfer from Essex County Medical Society.

A check-up of active members of the Society was made and it was noted that many physicians of the county are not members of the Society.

MATERNITY HOME

A letter was read from the New Jersey State Board of Health concerning the Dr. C. F. Smith Maternity Home. Dr. L. Bloom moved that the Dr. C. F. Smith Maternity Home for one patient to be located at Oxford be acceptable to the Warren County Medical Society and it so be recommended to the New Jersey State Board of Health. It was seconded and passed unanimously.

WOMAN'S AUXILIARY

It was moved and seconded to make the next meeting a women's meeting to be held at the Phillipsburg Elks Club, the object being to organize a Woman's Auxiliary.

BULLETIN

It was moved and seconded that publication of a bulletin by the Society be under the care of the Secretary. This was carried unanimously.

OBITUARY OF DR. G. O. TUNISON

Resolutions on the death of Dr. G. O. Tunison were presented by the committee, Drs. Bossard, Cummings and Varney. They were accepted and ordered spread upon the minutes and a copy to be sent to the bereaved family.

ELECTION OF OFFICERS

Drs. Bossard, Curtis and Shimer were appointed a nominating committee. The following nominations were made, and were unanimously elected officers for the ensuing year:

President, Dr. William Varney, Washington.
Vice-President, Dr. James Weres, Alpha.
Secretary, Dr. William F. Skinner, Washington.
Treasurer, Dr. G. W. Cummings, Belvidere.
Reporter, Dr. H. B. Bossard, R. D. 2, Phillipsburg.
Censor, 3 yr.—Dr. Herman Baldauf, Belvidere.
Delegate, 3 yr.—Dr. F. A. Shimer, Phillipsburg.

Alternate Delegates for one year:

For Dr. L. Hacket, Washington—Dr. H. B. Bossard, R. D., Phillipsburg.
For Dr. F. W. Curtis, Stewartsville—Dr. W. F. Skinner, Washington.
For Dr. F. A. Shimer, Phillipsburg—Dr. J. Lemmon, Washington.

SCIENTIFIC

Following the business part of the meeting, the Society was honored by an excellent address on "Traumatic Ruptures of the Liver and Spleen and Ruptures of Gastric and Duodenal Ulcers, Diagnosis, Treatment, and End Results", by Dr. Paul Correll, Surgeon in Chief of Easton Hospital, Easton, Pa.

The paper was discussed by several of the members present.

The meeting then adjourned to the dining room, where an excellent dinner was served.

THE WOMAN'S AUXILIARY

STATE EXECUTIVE BOARD MEETING

Mrs. Edna L. Nicholson, Reporter

The first Executive Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at the home of the President, Mrs. Frederick A. Kinch, at Westfield, on Monday, October 14th. After the reading of the minutes, several letters were heard from the past and present national Presidents congratulating New Jersey on her entertainment at Atlantic City in June, and speaking of her as a "master of hospitality".

After the reports of the different chairmen, the meeting was addressed by Miss Church, of Crossnore School and Hospital, North Carolina. She gave a very realistic and enlightening talk on the work being done by a doctor and his wife in the mountains—real pioneering in the twentieth century.

The speaker of the day was Dr. E. W. Sprague, of Newark, chairman of the State Society Advisory Committee to the Woman's Auxiliary. His subject was most interesting, as he described the conditions and problems of the medical profession. He spoke at length of the *Washington Plan*, and left us with the consoling idea that the patient's welfare is still the big thing in a doctor's life, and that idealism still plays a big rôle in the practice of medicine today.

Middlesex County has just formed an Auxiliary, making it the fifteenth in the State. It was represented very ably by the President.

The chairmen of Public Health and Public Relations—Mrs. Don Epler, of Newark, and Mrs. A. Haines Lippincott, of Camden—gave outlines for work in the coming year.

A very delightful report of the thirteenth convention held at Atlantic City was read by Mrs. George A. Rogers, of East Orange. Mrs. A. J. Casselman, of Camden, a member of the National Board, was present.

The welcome by Dr. and Mrs. Kinch will be remembered. The cosy, friendly atmosphere of the house was charming, and the delicious and bountiful luncheon was a treat indeed. Graciousness presided in the person of the new State President, Mrs. Kinch.

Atlantic County

The first meeting of the *Atlantic County Auxiliary* was held Friday evening, October 11th, at the President Hotel, and was opened by an address by the President, Mrs. Carl Surran.

A Hallowe'en dance to be held in the Submarine Grill of the Traymore Hotel was discussed, and all members were urged to come in costume.

Dr. Edward H. Harvey spoke on the subject, "What I Think of the Woman's Auxiliary of the Atlantic County Medical Society". In his address he spoke of the importance of the contact between the doctor's wife and his family, and the medical profession; and suggested activities which might promote the spirit of friendliness between the two.

Mrs. John Lloyd, Jr., entertained with original monologue interpretations. "At the Perfume Counter" was among the delightful ones presented.

Bergen County

The first meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held at Hackensack Hospital Tuesday evening, October 8th, 1935. The speaker of the evening was Dr. Karl Ritter, Tenafly High School, Tenafly, N. J. His topic was "A Wholesome Personality", in which he showed how factors of health, environment, and association tend to influence that element of the indivudal character called "Personality".

Mrs. Alvah Bickner, President, presided at the business session, during which plans were presented and discussed as to activities for the coming year. Various philanthropic and social programs will be decided upon at a succeeding meeting.

Hudson County

The first meeting of the new year of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Tuesday, October 1st, at the Y. W. C. A., Jersey City, N. J. The minutes of the last meeting, which was held in May of this year, were read and approved. Reports were made by the retiring chairmen of all committees.

Mrs. Frank Nicholson, our retiring President, gave a résumé of all that had been accomplished during her term as President and thanked the members of all committees and the ladies of the Auxiliary for their very fine coöperation. She was then presented with the Past President's Pin by Mrs. John Nevin. Mrs. Nicholson's report was as follows:

THE REPORT OF MRS. EDNA L. NICHOLSON, RETIRING PRESIDENT

I shall give a short résumé of our activities during the past two years. As you know, our interests and activities have been varied. The meetings have consisted of routine business, health subjects, charity, discussion of radio programs of the A. M. A—the furthering of the program outlined by the State. We have had interesting speakers for the latter half of each meeting.

We have managed, under the untiring effort and magic ability of our dear Chairman of Entertainment, Mrs. Charles B. Kelley, to have our social activities attractive with card parties, luncheons, Christmas festivities, spring affairs, and, as a grand

finale, a supper dance at which our husbands met our Auxiliary associates—learned what the Auxiliary really means. Our charity, with a few exceptions, has been confined to a contribution towards rent for a needy case; otherwise we have tried to save every cent for the one worthy project—the Doctors' Home.

1933-1934

In October we met and planned how we might
Be a real Auxiliary and help in the fight
Against want and disease and insects wiggly;
And for new ideas, we asked Dr. Quigley.

And so we gained ideas for the whole year.

Dr. Charles B. Kelley, with a most enlightening talk on "State Licensure of Physicians", making us understand and appreciate more fully the gentleman at home.

December brought our home talent Christmas party, with the Christmas carol living again through the personality of our darling Mrs. Nevin.

In January we combined our interests with welfare work, and were addressed by Miss Martha A. Bonham of the New York Foundling.

February brought Dr. Edward Berman, of the Junior High Vocational School for Boys in Bayonne, who told of our relationship to his work, and of his bureau for cosmetic servants.

In March Mr. William C. Christy spoke on smoke abatement in regard to health, and gave us a most informative talk.

In April—
Our ideas of Jersey were very poor,
So we sent for the Governor—A. Harry Moore.
He told is in story and told us in rhyme,
Beginning with "Once upon a time—"
He left us elated and very proud
That in Jersey graves we'll wear our shroud;
But prouder yet about oysters and peaches
And that we still can cavort on Jersey beaches.

In May, Dr. B. T. D. Schwarz gave us a complete understanding of the Widows' and Orphans' Fund, and from his talk we hope for new members. We all remember the lovely Arcola luncheon.

1934-1935

Our first meeting was opened with Miss Woodruff as our speaker. She took us travelling with tuberculous germs and stressed care in adolescence.

Dr. J. Von der Leith in November talked to us about micro-organisms and their relation to diagnosis and preventive medicine.

December brought our unforgettable Christmas party, with music, song and story, an Italian singer and accompanist, the Story-Teller, the Street Singer and his accordion, Old-World movies—ending all with Christmas carols and an Irish jig.

January was all business with reports and plans discussed—Widows and Orphans, Hygeia and Speakers' Bureau stressed.

In February we were addressed by Dr. Charles Kemm Good on the general care of the skin and use of cosmetics. The talk proved most interesting, judging from the questions afterwards.

March brought much information from Mr. J. C. Reiss, of Newark; he dispenses glasses on medical prescriptions only.

In April we had election of officers and a charming review of "The Dog of Flanders" by Mrs. Nevin.

In May we entertained our State President, the President of Essex County and other dignitaries, and a fine talk was given by Dr. Pollak and an invitation extended to us to visit the county institutions.

This report may sound very inadequate covering a period of two years. I have enjoyed being with you every minute, and thank you for all that you have given me in ways that you can never know. I regret that I could not make a fairer exchange of personality, and bring more outstanding qualities to you—but you all mean much to me and I thank you sincerely for your coöperation and help. I wish to make a special tribute to: Past Presidents, Mrs. William Friele, Mrs. John Nevin, Mrs. George Culver; Recording Secretary, Mrs. John N. Connell; Corresponding Secretary, Mrs. Frank Haggerty; Treasurer, Mrs. Harry Perlberg; and the following Chairmen: Entertainment, Mrs. Charles B. Kelley; Program, Mrs. Joseph Murray, Mrs. Arthur Largay and Mrs. Warren Duckett; Press and Publicity, Mrs. George Culver; Hygeia, Mrs. Joseph; Widows and Orphans, Mrs. B. T. D. Schwarz; Membership and Telephone, Mrs. James Murphy and Mrs. A. E. Jaffin; Legislation, Mrs. Ruoff; Public Relations, Mrs. Facciola; Speakers' Bureau, Mrs. Edward G. Waters; Reporter on Broadcasts, Mrs. James Murphy. And a last "thank you" to all the hostesses and members.

After again thanking the members of the Auxiliary, Mrs. Frank Nicholson presented the gavel to the incoming President, Mrs. Abraham Jaffin, who introduced her associate officers, who are as follows: Vice-Presidents, Mrs. Charles B. Kelley, Mrs. Arthur Largay, Mrs. Andrew Ruoff; Treasurer, Mrs. Harry Perlberg; Recording Secretary, Mrs. Edward Waters; Corresponding Secretary, Mrs. Frank Haggerty.

Mrs. Jaffin then gave a short talk outlining the aims of the Auxiliary. She explained that the organization is not only a social one to promote good fellowship among doctors' families, but is also to assist the Medical Society whenever called upon. Right now we can help by building up an audience for the medical talks which will be presented over Radio Station WJZ each Tuesday at 5 p.m. by the American Medical Association.

Mrs. Edward Waters, the Recording Secretary, read the names of the members of the different committees who are to serve this year:

Program Committee: Mrs. Arthur Largay, Mrs. William Friele, Mrs. Vincent Butler.

Public Relations Committee: Mrs. James Murphy, Mrs. Julius Siegler, Mrs. Henry Klaus, Msr. Aloysius Rieman, Mrs. Frank Mallalieu, Mrs. Frank Facciolo.

Entertainment Committee: Mrs. Lewis Dodson, Mrs. Samuel Barishaw, Mrs. Peter Maras, Mrs. Ellis Chapman, Mrs. Henry Klaus, Mrs. John Madaras, Mrs. Joseph Ruvane.

Press and Publicity Committee: Mrs. Joseph Murray.

Telephone and Members Committee: Mrs. Miles T. Long, Mrs. Bernard Kelly, Mrs. Herbert Culver, Mrs. Oscar Jacks, Mrs. Herman Jaffe, Mrs. Harold Hoops, Mrs. Albert Greene, Mrs. Lewis Perkel, Mrs. J. Searle McDede, Mrs. C. A. Peterson, Mrs. Henry Schwarz, Mrs. Emmet Connell, Mrs. Frank Mallalieu, Mrs. William Mulvihill.

Historian: Mrs. William Barbarito.

Widows and Orphans Committee: Mrs. B. T. D. Schwarz.

The meeting adjourned and was followed by a social hour during which tea was served by Mrs. J. Searle McDede and a group of hostesses.

Monmouth County

Reported by Mrs. W. K. Campbell, President

The quarterly meeting of the *Woman's Auxiliary of the Monmouth County Medical Society* was held September 30 at the State Hospital, Marlboro, at which time the members were luncheon guests of Dr. and Mrs. J. Berkeley Gordon.

Following luncheon a short business meeting was held under the direction of Mrs. William K. Campbell, of Long Branch, the President, and reports of officers and committee chairmen were given. After an interesting address on the work of the institution, Dr. Gordon conducted the women on a tour of inspection throughout the building, pointing out the many points of interest.

The next meeting of the Auxiliary will be held in Freehold, December 2 at the home of Dr. and Mrs. John C. Clayton.

Attending the meeting were Mrs. William K. Campbell, Mrs. Stanley Nichols, Mrs. John E. Maher, Mrs. C. Byron Blaisdell and Mrs. Harry B. Slocum, of Long Branch; Mrs. John C. Clayton, Mrs. H. H. Friedman, of Freehold; Mrs. Murray Woronoff, of Keyport; Mrs. William G. Herrman, of Deal; Mrs. Robert Watkins, of Belmar; Mrs. Robert Mackenzie, of Interlaken; Mrs. Otto R. Holters, Mrs. William Gillum, Asbury Park; Mrs. Frederick Bullwinkel, Atlantic Highlands, and Mrs. J. Berkeley Gordon and Mrs. Granville Jones, of Marlboro.

Somerset County

Mrs. C. F. Halsted, Reporter

The *Woman's Auxiliary to the Somerset County Medical Society* were guests of the Medical Society at their annual dinner held at the "Old Mansion", Raritan, New Jersey, Thursday, October 10, 1935.

A meeting of the Auxiliary was held prior to the dinner, and Mrs. Stilwell presided. Those present were Mesdames Stilwell, Flint, Hegeman, Barbour, Young, Knight, East, Renner, Sferra, Brittain, Fisher, Gray, Adams and Halsted.

Mrs. Renner gave a résumé of the Eighth Annual Meeting of the Auxiliary held in Atlantic City, May 1, 1935. The delegate stressed a plea made by the Chairman of the Widows and Orphans Society for greater coöperation from Auxiliary members. Mrs. Renner also advanced the name of Mrs. A. Haines Lippincott from whom the names of special speakers might be obtained.

Mrs. Stilwell appointed the following committees:
Social—Mrs. Lawton and Mrs. Brittain.
Hygeia—Mrs. Sferra.
Legislation—Mrs. Renner.
Widows and Orphans—Mrs. Gray.
Archives—Mrs. Ely.
Public Health—Mrs. Young.
Publicity—Mrs. Halsted.

Union County

Reported by Mrs. Helen M. Murphy, Publicity Chairman

The *Woman's Auxiliary of the Union County Medical Society* was delightfully entertained at its first meeting of the season, on Wednesday evening, October 9th, at the home of Dr. and Mrs. H. V. Hubbard, Plainfield. The new President, Mrs. F. B. Gilpin, was in the chair.

Plans were made for a tea to be given on October 30th, and a card party to be held on November 20th.

After the business meeting, Mrs. H. D. Corbusier gave a most vivid and interesting résumé of the "Odyssey Cruise", a trip which she and Dr. Corbusier took this past summer.

DECEASED PHYSICIANS

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Marcus Seidmann	75	Sept. 6, 1935	580 High St., Newark	Same	Coronary artery disease.
Isadore Topkins	64	Sept. 2, 1935	365 Osborne Ter., Newark	Califon, N. J.	Coronary sclerosis. Pulmonary infarction
Theodore Senseman	60	Sept. 8, 1935	Atlantic City Hosp., Atl. City	117 N. Osborne Ave., Margate	Pulmonary tuberculosis.
Cyrus B. Phillips	77	Sept. 16, 1935	74 Pitman Ave., Pitman	Same	Acute indigestion. Cardiac asthma.
Neil McLeod	34	Sept. 23, 1935	Jackson T'wns'p, Ocean Co.	4107 Chester Av., Phila., Pa.	Automobile accident.
Frederick P. Wilbur	55	Sept. 8, 1935	6 Evans St., Franklin	Same	Angina pectoris.

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. . .

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We believe you will enjoy them.

ANNUAL MEETING, JUNE 2-4, 1936, IN HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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Three Essentials

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Number 12

THE JOURNAL
OF
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Under the
Direction of the
Committee on Publication



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Frank Overton, M.D., Dr. P.H.

Offices of the Society—137 East State Street, Trenton, N. J., Tel. 9330
Executive Officer—LeRoy A. Wilkes, M.D.

Each member of the State Society is entitled to receive a copy of The Journal every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on pages iii-v of the Advertising Section.

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EDITORIALS

The Specialty of Medical Society Administration

The County Medical Society acting as the health adviser of the community is a modern phenomenon for which there has been no precedent. This conception was born a half-century ago along with the proof of the germ theory of disease which opened up the vast field of the practice of preventive medicine. Physicians left the practice of the new branch of medicine largely to nurses, dietitians, welfare officials, school teachers, economists, and endowed foundations, for the people saw no need for paying the doctor for advice which they could get from a nurse or a dietitian free. The lay organizations therefore increased their sphere of influence until they began to dominate the medical profession and threatened to compel the doctors to become hired servants of the State. This threat aroused the physicians' renewed activity in their medical societies in order to develop better methods than the lay groups had planned.

The medical and the lay groups engaged in health work have now reached a state of mind in which each is aware of the peculiar field which belongs to the other. The delivery of the services of medicine and the use which the people make of the services require physicians to act in accordance with uniform plans which can be developed only through their County Societies—or more specifically, the *officers* of the societies.

In order that an officer of a County Society can plan with intelligence and act with efficiency, he must have practical knowledge and experience along at least four lines:

1. The medical needs of his community and the present means of meeting them.

2. What the medical societies of other localities are doing under similar circumstances.

3. What the lay health organizations have done, and are willing to do.

4. Judgment of the probable reactions of both the laymen and the physicians to his proposals.

Physicians who can attain a high rating along these lines are *specialists in medical society administration* whose services are invaluable to their medical brethren and to the community. They may be assured of recognition and encouragement, for it is from their ranks that the leaders of The Medical Society of New Jersey are recruited.

A. M. A. Conference of Secretaries and Editors

The annual conference of the Secretaries and Editors conducted by the American Medical Association on November 15 and 16, 1935, was exceedingly interesting and profitable. (See page 720.) It was notable for the presence of many faces that were new to many who have attended the meetings during the past few years. It was also notable for its social spirit, and the unusual opportunities of the delegates for getting acquainted with one another.

Possibly the subjects on the general program were too broad and deep for effective presentation, but there were abundant opportunities for expression of opinions. The very differences of opinion, which were sometimes acute, will have a tendency to bring the interested parties together for a friendly discussion of their differences.

The reasons for the misunderstandings were hinted in the remarks of Dr. Shanklin, Editor of the Indiana Journal, who suggested the need of some means of bridging the gap in understanding between the A. M. A. and the State Societies. The A. M. A. publishes a great amount of *impersonal* material, all of which is thoroughly appreciated by the State Societies. What is needed is the *personal* influence of two or three field secretaries whose sole duty is to visit the officers of the State Societies on a friendly basis and discuss the problems over which misunderstandings arise. New Jersey has previously suggested this project informally. If the system had been in operation in past years, acute differences of opinion could have been explained before they developed to an aggravating degree.

As was pointed out by Dr. Morrison at the conference, New Jersey stands at the head of the list of the States in its proportion of physicians who are either fellows of the A. M. A. or subscribers to the A. M. A. Journal. This fact is shown in the table, printed on page 554 of this Journal of October 1934, based on the published statistics of the American Medical Association.

New Jersey will welcome the field visitors who may be sent out by the American Medical Association.

The Approach to Legislators

The Medical Society of New Jersey recognizes members of the Legislature as co-workers in the field of public health, for they have the final decision regarding the forms of official health services, and they supply the funds for their support. (Journal Nov. 1935, p. 625.)

The leaders of the Society have scrupulously avoided the methods of seeking a pledge from a candidate or officeholder regarding his attitude toward prospective bills. They prefer to inform the legislator regarding the merits of each medical bill as it comes up, and to rely on his own good judgment to determine his attitude toward it.

These sentiments were expressed in the following letter which was sent on October 10 to every candidate for election as a member of the Legislature of New Jersey by Dr. LeRoy A. Wilkes, Executive Officer:

"This letter is meant neither to solicit favors nor to recommend legislation. Its whole purpose is to ask that you do not commit yourself in the Legislature on any bill or measure bearing upon public health without first hearing all sides of the question and being thoroughly informed on the subject.

"Useless and vicious health laws can do more harm to more people in less time than almost any other kind of legislation.

"No other subject is more important than public health and the medical, sanitary and hygienic procedures and processes which affect individuals. In no other field are special privileges more sought after in the Legislature.

"If the future may be judged by the past, scores of bills will be introduced in the next Legislature by various organizations and agencies interested in some special privilege concerning public health and medical practice.

"It is well to remember that almost any individual or group can present a splendid argument when only one side of the proposition is heard. Our sole request is that you keep an open mind on all questions pertaining to public health and

until all sides have had a fair hearing. In this request we speak not only in behalf of the 4000 physicians in New Jersey, but also for that great body of good citizens who place their confidence and faith concerning health matters in their physicians and in the state and local health departments.

"May we respectfully call your attention to the fact that medical and public health practice is one thing which has not depreciated either in value or public confidence during the past few years. Indeed, health conditions have been maintained since 1929 at the most favorable level on record. New Jersey has the most favorable health record of any state in the Union with a comparable population. During the distressing period of the economic emergency, health has been maintained in this State at the unusually favorable level reflected in the prevalent mortality and disease rates.

"The medical profession of the State is pardonably proud of that record. We are anxious to maintain it unimpaired in the future.

"For these reasons The Medical Society of New Jersey asks that its representatives be heard before any bills on medical or kindred subjects receive your indorsement. It asks that you come to the State House with an open mind, and that you hear the views of the organized medical profession before voting on medical and public health bills."

The reaction of the candidates was unusually favorable. Among several letters of reply the following was typical:

"Your letter was so utterly different from most letters sent to candidates or legislators by groups or blocs that I cannot let it go unanswered.

"Some years ago I served two terms in the Assembly and found the experience a liberal education. Among other things, I learned generally to distrust, and frequently, to despise, lobbyists.

"Except where there is a matter of principle involved, I have found that there is usually something to be said on both sides of any question coming before the Assembly. I will try next year, as I tried during my other two terms, to keep an open mind on 'all questions pertaining to public health', and, indeed, to the public welfare generally.

"Your letter appealed to me because it was as fair a statement of a position as could be made by anyone, and I shall keep it as an example of what a group like yours can really do to be of assistance to law makers, who are simply trying to perform their duty without thought of political consequences."

It is gratifying that the open mind is a direct highway by which the physician and the legislator may approach each other.

The Federal Pure Food and Drug Law

The Copeland Bill in the United States Senate proposes to amend the present Pure Food and Drug Law, popularly known as the Wiley Law, after Dr. Harvey Wiley, who was its greatest sponsor. The Wiley Law provides for a commission which analyzes specimens of foods and drugs, and begins legal actions against manufacturers and dealers whose wares do not conform to the required standard of strength and purity.

A valuable feature of the Wiley Act is its provision that the prosecution of an offender is *mandatory*. The Copeland Bill would *permit* the authorities to refrain from starting a prosecution if, *in their judgment*, the offense is of a minor nature. This provision of the Bill would not only go far toward nullifying its purpose, but would open the way to bribery by manufacturers seeking exemptions under the law. It is always dangerous to allow an official to be the inspector and the judge, as well as the prosecutor.

The administration and enforcement of the Wiley Act has always been difficult from the very nature of the conditions with which it deals. However, there is a widespread feeling that the officials have been exercising too much of that freedom of choice which the Copeland Bill would legalize. The enforcement of the Law was investigated by a committee of one of the County Medical Societies of New Jersey, and court records, which were received from Washington, showed inequalities of enforcement, especially a severity of punishment for lesser offenders, and a leniency for large manufacturers who could command unlimited means of defense. These conditions have been brought to the attention of the American Medical Association first by a few public-spirited members of The Medical Society of New Jersey and later by the House of Delegates; but the meager replies which were received from the Council on Pharmacy and Chemistry of the A. M. A. and from some of its other officials were unsatisfactory to New Jersey physicians. The result has been that a considerable degree of misunderstanding has arisen between the A. M. A. and the New Jersey organiza-

tion concerning the endorsement of the Copeland Bill.

The Medical Society of New Jersey is concerned with past events to a far less degree than with what will occur in the future. It takes the stand that the permission clause of the Copeland Bill is a backward step which would nullify the Wiley Law.

It believes that the leader in the opposition to the permissive feature of the Copeland Bill should be the American Medical Association.

Whatever may have been the misunderstandings in the past, the present problem is the Copeland Bill. A definite expression of opposition to its *permissive* provision for prosecuting offenders must be issued in the very near future in order to secure the elimination of this objectionable feature. New Jersey wishes to act in harmony with the A. M. A., and suggests that a friendly conference of a few representatives of the two organizations be held for the purpose of securing a concert of action by the State and National organizations.

Executive Committee of a County Society

The need that every County Society, large or small, should have an Executive Committee is self-evident to anyone who has to seek an opinion, or secure an action from the Society, as the officers and committees of the State Society have to do frequently. The need is not merely a *desirability;* it is a *necessity.*

Often when an immediate reply is requested, the answer is that the matter will be brought before the Society at its very next meeting,—which may be weeks in the future. A consideration of the form of government of a County Medical Society will explain the reason for the Executive Committee.

FORM OF GOVERNMENT

A County Society is essentially a democracy in which every member has a voice; but even in a pure democracy, there are two branches of government,—the *legislative,* composed of all the citizens, and the *executive,* composed of elected leaders.

The legislative branch of a County Medical Society meets at intervals which are infrequent and fixed by the By-Laws of the Society. It determines general policies, and elects officers who carry out the details of putting those policies into effect.

The elected officers constitute the *executive* branch of the government of the Society. These county officers receive prompt notice of the development of the projects of the State Society, many of which require immediate action. Local conditions also develop in which timely action by the officers of the County Society is necessary lest the situation pass beyond control. The Executive Committee can deal with emergencies as soon as they arise; it can hold special meetings on the call of the President, with the reasonable assurance that its action will be approved by the Society at its next stated meeting. Those Societies which have an active Executive Committee are noted for their efficiency, and for their leadership in all local health movements. Read the routine County Society reports in The Journal and note the reports of the Executive Committee meetings of the more active Societies.

COMPOSITION AND FUNCTION

The Executive Committee of a County Society will naturally be composed of the President, Vice-President, Secretary, and Treasurer, to whom the chairmen of the more important committees may be added. The President will act as Chairman, by virtue of his being the chief executive officer of the Society.

The Committee will discuss the projects which are to come before the general meeting of the Society and will ascertain the opinions of the members. It will report to the general meeting of the Society on its findings, the actions which it has taken, and the attitude which it advises the Society to adopt. Seldom will a Society disapprove the action of its Executive Committee.

The members of a County Society which has an active Executive Committee are usually well informed regarding the activities of the Society, and are ready to support its projects.

Index of Volume Thirty-Two

This December issue completes Volume 32 of *The Journal of The Medical Society of New Jersey,* which was founded on September 1, 1904. The half-decade 1901-1905 was a period of expansion of the activities of the Medical Societies of the several States, as demonstrated by the founding of many of the State Journals. These were days when the discoveries in bacteriology and immunity were consolidated so that any physician could apply them in his practice. Equally great advances were made in pathology and diagnosis. There was, therefore, a great need that the means should be provided for making the newer knowledge available to physicians generally; and still more,—to persuade doctors to put them to use.

A potent means of inspiration to the physicians of New Jersey was the example of local leaders who were known to the physicians of New Jersey. A report of diphtheria immunizations by a well-known physician of Newark, for example, would compel recognition when a similar report from Chicago might go unrecognized. The major object of The Journal of The Medical Society of New Jersey was to provide the medium for making the scientific writings of New Jersey physicians known to their professional brethren. Every New Jersey physician who published a scientific article conferred a favor on his confreres. That condition still exists, and today, the most widely read department of The Journal is that devoted to scientific medicine.

The last decade has seen the rise of preventive medicine and the entrance of lay health organizations in its field, and the recognition of the necessity that Medical Societies should assume their rightful place as advisers of the community. This meant that every physician should take an interest in the practice of what may rightfully be called *civic medicine,* for the benefit of *himself* as well as that of the community. The leaders of the Medical Societies have recognized the need by making discussions on the *public relations* of medicine a place on the programs equally as great as those on scientific medicine. The result has been that *The Journal* has become a text-book of major importance to every practitioner of medicine. In fact, The Journal of The Medical Society of New Jersey is the principal source of information to its members on the subjects of medical relations and the practice of civic medicine.

An annual index of contents is a necessity in making the records of the activities of the Medical Societies of the State and counties available for easy reference. Last year those activities recorded in The Journal and the Transactions were indexed fully for the first time. The value of the index is appreciated most by those who have occasion to use the records most frequently. The officers of the Society and especially the staff of the Executive Offices, have had occasion to consult the index many times every day, not only for ascertaining what has already been done, but also as the foundation for future progress, and the avoidance of repetitions of experiments whose value has already been demonstrated.

The index this year is even larger than that of last year, in keeping with the great progress that has been made in the assertions of medical leadership in competition with that of lay health organizations and government officials. The natural medical leaders in civic medicine are the family doctors and practicing physicians who are in close contact with the people and with local office-holders.

The two title pages of the index are not numbered, in order that they and the index may be removed and bound in the front part of the year's volume.

Preserve the index that is contained in this number of The Journal beginning on page 737, and keep it in a place where it may be consulted instantly.

How Dues Are Spent

In this season for the collection of annual dues, the members of The Medical Society of New Jersey wish to know how their dues are spent. The Transactions of 1935, page 8, contain a table prepared by the Treasurer, Dr. Elias J. Marsh, showing how much of the thirteen dollars dues were spent for each specific purpose.

A similar table was prepared by Dr. Marsh in 1930, when dues were $15, and was published in the Transactions of that year, page 20.

The two tables are here reprinted side by side for easy comparison:

1930		
Publication	$ 2.32	
Editor	1.90	
		$4.22
Welfare Committee	.28	
Executive Dept.: Salaries	3.45	
Executive Dept.: Expenses	2.31	
		5.76
Recording Secretary's Office	1.32	
Treasurer's Office	.02	
Delegates to A. M. A.	.23	
Printing and Stationery	.66	
Tristate Conference	.06	
Miscellaneous and Contingent	.60	
Reserve (Permanent Fund)	1.15	
Balance	.70	
	$15.00	

1935	
Journal, editing and publishing, but excluding share in general office expense, net	$ 3.75
Executive Officer, salary and expenses	2.03
Office rent, services and expenses	1.43
Office, equipment and furnishings	.50
Secretary, salary and expenses	.97
President's office, expenses	.05
Treasurer's office, expenses	.02
Welfare Committee	.30
Public Health Committee	.05
Arrangements Committee	.10
Other committees, expenses	.06
Printing, postage, and stationery	.69
Annual Meeting, 1934	.51
Legal services	.78
X-ray boxes	.04
A. M. A. Delegates, railroad fares	.03
Miscellaneous	.19
Balance	1.50
	$13.00

It will be noted that the expense per member has not increased although there has been a great increase in the scope of the activities of the State Society and of the contacts of the central office with the County Societies and the members.

Belated Discoverers

The "New Dealers" claim to be the original discoverers of the "Forgotten Man" and for his special relief invented the "Fair Deal". They recognized his need for the basic necessities of food, clothing, shelter, and warmth, and added a fifth—medical care—asking statisticians and political economists and milk dealers for methods by which he could obtain medical attention.

Then said the New Dealers, "We will send physicians to treat you and they will be the best that money can buy."

But the Forgotten Man replied, "I have always had a good doctor, as good as any in the country, and he will come whether we pay him or not. He is different from the grocer and the tailor. We have to pay them or else go hungry and cold."

When the New Dealers discovered his perverseness and his insistent preference for his own doctor, they went to the physicians and asked them for a plan of service, and the reply which they got was, "We will be responsible for satisfactory medical service to the Forgotten Man if you will pay the bill just as you now pay the grocer and the tailor."

Then the New Dealers for the first time asked the Forgotten Man what he thought of the plan of the doctors, and he replied, "Give me my own doctor every time. He understands me and can pull me through, if anybody can."

Who can doubt that the final decision regarding the Forgotten Man will be that he will be treated by his family doctor in the future as in the past.

ORIGINAL ARTICLES

INFANTILE GLAUCOMA

By Willard G. Mengel, M.D., Camden, N. J.

Read before the Eye, Ear, Nose and Throat Section at the 169th Annual Meeting of The Medical Society of New Jersey, May 2, 1935, at Atlantic City

Increased intraocular tension, affecting one or both eyes, during early life is frequently designated *infantile glaucoma*. The condition has been referred to by different authors as congenital glaucoma, hydrophthalmos, and buphthalmos.

When present at birth or during the first several years of life, marked enlargement of the eyeball results. This condition with large globe is more frequently termed buphthalmos, from the Greek, meaning "ox-eye". Increased intraocular tension may not develop until the sixth to the eighth year, when little or no enlargement of the globe results. In these cases the condition is one of infantile glaucoma and not buphthalmos, as no enlargement of the eye-ball is detected. Buphthalmos is a form of infantile glaucoma, but all cases of infantile glaucoma are not buphthalmos, in which there is a characteristic enlargement of the eye-ball. Juvenile glaucoma is to be distinguished as occurring slightly later than infantile glaucoma, or during the second and third decade of life.

Verhoeff[1&17] believes buphthalmos, infantile glaucoma, and juvenile glaucoma represent differences in degree of the same congenital defect. In infantile and juvenile glaucoma the outflow from the eye is not as completely cut off as in buphthalmos and therefore there is not enough increase in the intraocular tension to enlarge the globe.

Buphthalmos has been reported in association with many congenital defects. Aynsley[2] in 1929, Ballantyne[3] in 1930 and Pi[4] in 1931 reported the association of buphthalmos and naevus. The presence of neuro-fibroma with buphthalmos was noted in 1934 by Weber[5] and Bode. Hardesty[6] in 1934 detected hyperactivity of the thymus in cases of buphthalmos. Congenital anomalies of the iris, such as coloboma, corectopia, and aniridia, have been described.

The hereditary nature of infantile glaucoma has been noted frequently because of its appearance in more than one member of the same family group. Hymes[7] reported the appearance of buphthalmos in sisters. The condition was bilateral in each case. Kiehle[8] and Pugmire found buphthalmos in identical twins, with the right eye affected in the one, and the left eye in the other. These were detected at three months of age. Trephine operation was performed in one and enucleation in the other. The influence of heredity is well marked; although direct inheritance is rare.

COURSE

The progress of the disease is slow, and probably always dates from birth or before. Gros[9] collected forty-five cases of buphthalmos, in which twenty-seven were present at birth or during the first week; six were detected during the first year; eight were present from the first to the third year; two were detected at eight years; and two at fourteen years of age.

Buphthalmos is usually bilateral. Frequently, there is a unilateral enlargement or buphthalmos, with the other eye apparently normal in size, but showing an increase in tension, as determined by the tonometer. Owing to its insidious nature, cases rarely come under observation until the condition is fully developed. Infantile glaucoma without enlargement of the eyeball is usually detected, only because of the suspicion thrown on it by the enlargement or buphthalmos of the fellow eye.

DIAGNOSIS

The characteristic features of buphthalmos are readily detected. The striking enlargement of the eyeball, the large globular cornea, the

excessively deep anterior chamber, the bluish color of the sclera especially at the limbus, the glaucomatous cupping of the nerve head, and the moderately increased intraocular tension, indicate quickly and clearly the condition of buphthalmos.

In the other form of infantile glaucoma, in which there is little or no enlargement of the eyeball, the condition is frequently undetected. The slow, insidious onset, without symptoms or inflammation, in children, renders the diagnosis extremely difficult. The eyeball and cornea are apparently normal in size. There are no complaints of pain or redness. A moderately increased intraocular tension and a deep anterior chamber are the only positive findings in the early cases. Later, glaucomatous cupping, visual field changes, especially in the nasal portion, and myopia are observed.

Controversy exists over the various factors causing infantile glaucoma. Collins [10] held that there was an incomplete separation of the root of the iris from the cornea in the angle of the anterior chamber. He stated that this was a persistence of the pre-natal condition of the pectinate ligament. Verhoeff [17] found on microscopical examination that there was a defective filtration angle. Obliteration of the canal of Schlemm had been noted by many authors; but this was thought by Parsons [11] to be a sequel rather than a cause,—similar to the obliteration of the canal in adult glaucoma by inflammatory changes.

Most observers were agreed that there was an obstruction to the outflow of fluid at the angle of the anterior chamber. Whether this was due to an arrest of development or inflammatory changes was an open question. Parsons [11] stated: "An arrest of development must have some cause, and this, most probably, is to be discovered in some intra-uterine inflammatory or toxic condition."

CASE REPORTS

Case I. History. W. H., a boy aged six years, was seen in June, 1934, because of failing vision in the right eye. The left eye had been blind for years.

Enlargement of the left eye was noticed first when five months of age. He had been examined and treated by several oculists at that time for the left eye. The right eye was said to have been normal when the enlargement of the left eye was first detected.

There was no history of glaucoma in his parents or in his younger brother. No other congenital defect was detected in patient or relatives.

Examination. The vision was 3/60 in the right eye, which was improved to 6/21 with glasses. In the left eye, the vision was reduced to the faint perception of light.

External Examination. Right Eye. The right eye appeared to be normal in size. No congestion of conjunctiva or lids was detected. The cornea was clear and measured twelve millimeters in horizontal diameter. The anterior chamber was deep. The

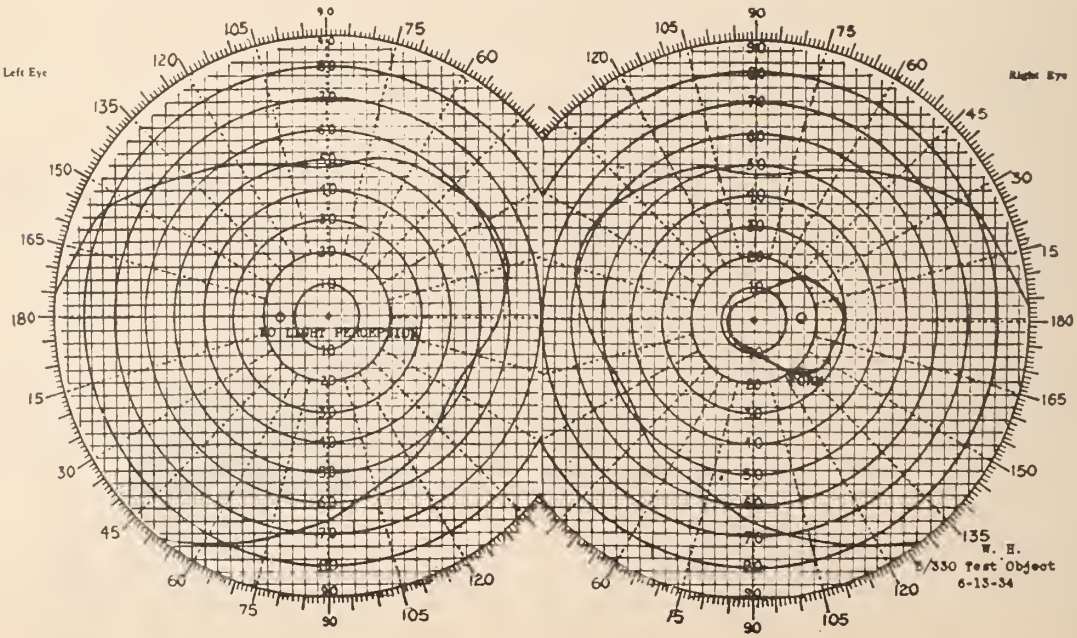


Figure 2.—Case I., W. H.

pupil was circular, four millimeters in diameter, and reacted to light and accommodation. No synechia could be detected. The tension by Schiotz tonometer was thirty-eight. The refractive error indicated a compound myopic astigmatism.

Left Eye. The eyeball was enormously enlarged. There was a slight ciliary injection. The cornea appeared hazy and was considerably enlarged, measuring sixteen millimeters in horizontal diameter. The anterior chamber was very deep. The pupil, seen through the corneal haze, was four millimeters in diameter and failed to react to light and accommodation. The iris appeared atrophic and was tremulous. There was a bluish appearance to the sclera along the limbus. The eyeball was hard because of the increased tension.



Fig. 1.—Case I., W. H.

Ophthalmoscopic Examination. Right Eye. The media were clear. The nerve head was pale, and showed a large, glaucomatous cup with underdipping of the blood vessels over the rim of the cup. The blood vessels, macula and periphery were normal.

Left Eye. No fundus reflex or details could be obtained.

The visual field of the right eye was cut to within the thirty degree circle on the temporal side, and within the ten degree circle on the nasal side.

The blood Wassermann and urine examination were negative.

Treatment. As the left eye was irritable at times, and hopelessly damaged with no vision, enucleation was advised.

Miotics were used in the right eye and temporarily reduced the tension, but after a number of weeks, were not effective, so that a trephine operation was performed.

A two millimeter trephine opening was made at the sclero-corneal junction. Through this a broad basal iridectomy was done instead of the small peripheral iridectomy, customary in the Elliott trephine operation.



Fig. 3.—Case II., M. W.

Following the operation, the intraocular tension varied between eighteen and twenty-three by the Schiotz tonometer. The vision with the myopic astigmatism corrected was 6/15. The visual field was the same as before the operation.

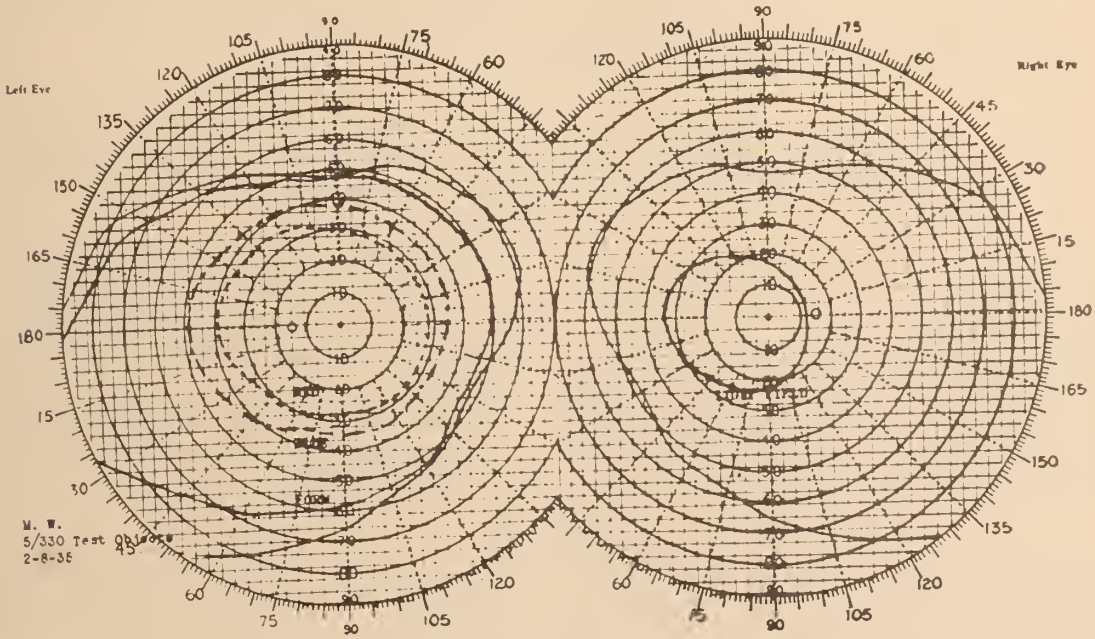


Fig. 4.—Case II., M. W.

Case II. History. Miss M. W., seven years of age, was seen in September, 1933, because of poor vision and turning out of the right eye. The condition had been present from birth.

Examination. The right eye showed a divergence of twenty degrees. Vision was 3/60 in the right eye and 6/30 in the left. With correction, the vision was improved to 6/30 in the right eye and 6/9 in

the left. The refractive error consisted of a myopia of ten diopters in the right eye, and a compound myopic astigmatism of moderate degree in the left.

External Examination. Right Eye. Slight enlargement of the eyeball was noted. There was no congestion. The cornea was clear and the horizontal diameter measured 12.5 millimeters. The anterior chamber was deep. The pupil was four millimeters in diameter and reacted slightly to light and accommodation. The intraocular tension was forty-five.

Left Eye. The eyeball was of normal size and showed no congestion. The cornea was clear and measured eleven millimeters in horizontal diameter. The pupil was four millimeters in diameter and reacted to light and accommodation. The intraocular tension was twenty-three.

Ophthalmoscopic Examination. Right Eye. A fine pupillary membrane was noted. Fine punctate lens opacities were detected. The nerve head was circular, slightly pale, and showed a large glaucomatous cup. The blood vessels, macula and periphery were negative.

Left Eye. The media were clear. The nerve head was circular, normal in color, and showed a central physiological cup, in which the lamina cribrosa was visible. The macula, blood vessels and periphery were normal.

The visual field of the left eye was normal, but that of the right eye was difficult to outline because of the marked myopia and poor vision. The right eye showed a decided reduction in the size of the visual field.

Treatment. Miotics when first used caused a moderate reduction in the tension of the right eye, but, after a number of weeks, they were no longer effective. The left eye frequently showed an increase of tension as high as thirty-five.

Because of the failure of miotics to reduce the tension, a trephine operation with a broad basal iridectomy was done in each eye, as in Case I.

Following operation, the intraocular tension varied between fifteen and thirty in the right eye, and between fifteen and twenty-two in the left. The vision with proper correction was 6/60 in the right eye and 6/9 in the left. The visual field of the left eye remained normal; and that of the right eye showed no further reduction.

COMMENT

In each of the above cases there was a unilateral buphthalmos originally, and in the fellow eye, infantile glaucoma developed subsequently. In Case I, the infantile glaucoma in the second eye was well advanced before detection. In Case II, increased tension in the fellow eye was detected early—before visual field change and glaucomatous cupping had developed.

Pupillary membrane and punctate lens opacities (probably congenital defects in development) were detected in the right eye of Case II, which was the eye affected originally by buphthalmos.

In this series of trephine operations on three eyes, the results have been satisfactory. The tension has been reduced to normal limits, the vision has been maintained, and the visual fields have shown no further reduction.

In each operation the combined effect of a broad basal iridectomy with a filtering trephine opening was obtained. No complications were encountered. There was no loss of vitreous, and no injury to the lens.

CONCLUSIONS

It is important to detect infantile glaucoma early, and before it has resulted in enlargement of the globe, reduction in vision, and glaucomatous cupping.

In unilateral buphthalmos, the fellow eye may insidiously develop infantile glaucoma, and must be regarded as a potentially glaucomatous eye, demanding careful examination and observation.

The trephine operation, combined with a broad basal iridectomy, is a satisfactory procedure in infantile glaucoma.

DISCUSSION

Charles Littwin, M.D., Englewood: In 1913 Dr. Zentmayer reported several cases of hydrophthalmus with a complete histologic report of two eyes. He wrote to a large number of ophthalmologists asking their experience in the type of operations used for that condition. An analysis of the replies he received showed that iridectomy gave fair results in 42 per cent of cases and poor results in 58 per cent; sclerotomy, 28 per cent fair results, 72 per cent poor; paracentesis, 100 per cent poor results; sclerectomy, 40 per cent satisfactory, 20 per cent encouraging, 40 per cent unsatisfactory; cyclodialysis, 100 per cent poor results; miotic treatment, unsatisfactory. On the whole then, some form of sclerectomy (LaGrange, Elliot—trephine or some modification) was the only method which gave satisfactory or encouraging results.

It is up to us ophthalmologists to do the best in our power to preserve vision and prevent progressive blindness with the best methods at our command; and in reports like these of Dr. Mengel's experiences can we hope to improve our own knowledge as to what those best methods are.

We are still far from the solution of the problem of glaucoma. Priestly-Smith defined glaucoma as an increase in intraocular tension, plus its causes

and effects. Every one has had the experience of a simple chronic glaucoma changing to the acute form under some circumstances of mental strain.

In glaucoma we are dealing with a condition in which there is some obstruction of those channels which allow the escape of fluid from the eye, rather than in the vessels that admit blood to it. We have a clue to the subject in the condition of hydrophthalmus which we know to be due, in some cases at least, to the obliteration or lack of development of the spaces of Fontana or canal of Schlemm. Not every one is liable to glaucoma, for after all it is comparatively infrequent, and we must realize that only certain individuals are susceptible to it; and then for some reason may have some peculiar condition of the tissues of the eye or of the vessels concerned with the outflow of fluids from the eye that render them liable, with a suitable exciting cause, to an attack of glaucoma. Persons who do not possess this peculiar type of vessels will not develop glaucoma even if subjected to the causes that would precipitate an attack in those so predisposed.

I venture to make the prophecy that at some future time we will come to the conclusion that glaucoma is a disease that will be cured, not by operative procedure alone, but by drugs, foods or hormones that will attack the basic factor of the disease. Just like insulin in diabetes, liver in pernicious anemia, vitamin A in keratomalacia and the female sex hormone in undescended testicles,—all of which remedies seemed far fetched in the beginning when those conditions seemed hopeless. Whether it will be pituitary extract, adrenalin or some unknown vitamin, remains for some future researcher to determine.

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STUTTERING—A NERVOUS MALADJUSTMENT, NOT A SPEECH DEFECT

By JAMES SONNETT GREENE, M.D.,

Founder, National Hospital for Speech Disorders, New York City

Read before the Medical Section of the Academy of Medicine of Northern New Jersey, in Newark in February, 1935

A public health service of absolute necessity is the Medical-Social Clinic—the clinic of the future—for only through its composite therapy can the phenomenon stuttering be permanently eliminated and adjustment be brought to the nervously maladjusted.

There is a group—their number is legion—who need this particular clinical service. They belong to a special type. I term them the stutter-type. They may or may not demonstrate stuttering speech, but their neuropathic tendency and hereditary inclination to stuttering strongly influences the individual, so much so, that his personality becomes disintegrated and presents a serious problem.

In this paper the stutter-type, demonstrating the physical manifestation, stuttering speech, will be briefly considered.

All stutterers have an inborn liability to nervous disturbance, due to an instability of the nervous system. Their stuttering is conditioned on certain states of mind in the form of emotions, feelings, attitudes or ideas. Uncannily they are moved back and forth between emotional balance and emotional imbalance, the result being ineffectual social adjustment. Their special nervous makeup is that of increased irritability with diminished capacity, a system which through a heavy hereditary disposition becomes easily affected from the least cause and is constantly threatened with a break. Their shocks of negative environmental factors are cumulative with the result that the repressed instinctive fear emotion is converted into the physical manifestation of stuttering. Their inferiority means fear, and fear means repression with its host of neurotic symptoms. Therefore, fully developed stuttering may be re-

garded as an anxiety or fear neurosis, and since the "stutter-type" is a confused, embarrassed and timid individual, it follows that there is a personality involvement which requires study and guidance.

Treatment should aim to consider the stutterer's whole personality, which is in keeping with the fact that the united complex life means both mental and physical. All physical disabilities and all psychic inhibitions must be considered. Through positive environmental factors release is brought about and the reactions to emotions are normal. Pathologic fear gives way so that expression or oralization is free and the speech disturbance disappears.

Our Medical-Social Clinic is a powerful motivating force for the integration of the stutter-type. It brings order and peace out of chaos and anxiety, the hope and wish of every stutterer. In our specially created environment he learns to acquire emotional stability so that he is capable of taking a non-hesitating stand, facing situations squarely and fearlessly. He not only gets tranquillized but keeps tranquillized. All this is brought about through a composite therapy of a medical, psychological, psychiatric, reëducational, and social nature.

Since the opening of our clinic seventeen years ago we have had the opportunity to study about 20,000 cases; 15,000 were of the stutter-type. The following chart gives our plan of reconstruction of the stutter-type. By way of illustration a few cases are briefly cited.

Experience has taught us that the initial interview with a stutterer is of far-reaching importance. The result of his entire course of treatment quite often depends on his initial contacts. The rebuilding of his personality starts at once. The doctor and the psychologist report on the physical and intellectual status of the individual. Recommendations on pertinent matters are made whenever indicated. Also before taking up treatment of his speech disorder, speech tests are made in our fully equipped radio department. Recording shows his speech condition before treatment began, and subsequent recordings show his improvement from time to time.

Case I. J. L. A young man, aged 24, occupation a bookkeeper, referred to the clinic by a physician. A severe stutterer, somewhat anaemic, rather underweight for his age and height, and so nervously tense that he suffered from sleeplessness as well as stuttering. No speech defect in his immediate family but an uncle on his mother's side stuttered. However, he seldom came in contact with him. As far back as he remembers he stuttered and did not know its onset. He gave the following history:

> For the first 18 years of my existence, life was hell. I did not live, I existed. Many were the times I wished I had lost a leg or an arm so that people would sympathize with my plight; but as I was a stutterer there was no understanding or tolerance forthcoming, only laughter, or quizzical expressions which seemed to say, "He must be an idiot or crazy."
>
> I did not understand myself, I only knew that when an occasion arose which necessitated speech my face became flushed, my heart palpitated, and I trembled all over. A jumble of unintelligible words, a gasping queer sound—chaos. Despondency, morbidity, and hate, were my companions. At home my shortcoming was not taken seriously. At school my defect was noted by the speech department. I was told to practice reading sentences with the letter "s".
>
> On graduation day I was a good physical specimen, but mentally I was a lost soul. My character was warped. I held a grudge against the world. I asked myself, "What now, is life worth living, stuttering as I do?"

On examination he was found to be a tense, nervous, maladjusted individual. Intellectually he was rather above the average. A physical examination disclosed nothing of a serious nature. His stuttering speech recording demonstrated muscular spasms, repetition of sounds, and crowing inspirations accompanied by hissing sounds. A thorough study of this young man's personality showed him to be suffering from a very marked sense of inferiority and from feelings of persecution. Behind his whole problem was a definite fear neurosis with its train of symptoms.

This young man was given a number of private conferences plus immediate contact with the various phases of our group therapy. At first he walked about shamefaced, embarrassed, awkward, feeling that his stuttering was a crime; but he very quickly was made to realize that his speech and its attendant processes is automatic, that ease and relaxation gives comfort and security in an atmosphere of calm and repose. His emotional conflicts were gradually solved. Mental and physical relaxation, a most important feature of his treatment, was brought about, so that his fear

of speech was gradually diminished and self-confidence came to the fore. He lost his nervousness and his sleeplessness. A special feature, which was rather difficult in his case, was the fact that he took himself entirely too seriously—living within himself. His marked introversion, however, was gradually overcome through our social therapy. He was compelled to participate in a number of our social endeavors which made a great change in his entire personality. Heretofore his bashfulness and timidity, coupled with his speech handicap, deprived him of social contact with the opposite sex. Our group therapy readily adjusted this condition and he was soon able to cope with society's conflicts in the clinic. This gradually encouraged him not to shun male or female society outside of the clinic. We worked towards a specific goal—that of an integrated personality with normal speech—which he has now attained.

Case II. H. G. A pronounced stutterer, 32 years old, occupation a mechanic, married. Referred to the clinic by a social agency. His reason for seeking help was that his three-year-old child, a very timid little girl, highly emotional, afraid of everything, and who resembled him very much, was to his way of thinking about to develop stuttering speech. So as a preventative measure for the child he was intent on getting cured himself very quickly.

His history brought out the fact that being brought up in an orphanage he felt that he missed a great deal in not having any relatives, always envying children who had them. At the age of six he was taken home after his mother remarried. His step-father proved to be shiftless, irresponsible and mean. Life after that was years of poverty, distress and humiliation, making the home upset and unpleasant. The shocks of environmental conflicts caused him to stutter.

School was a hardship. He felt inferior on account of his defective speech. Left school in seventh grade and went to work, but attended evening high school and a public art school. His work proved satisfactory because he had natural mechanical ability. He never derived satisfaction or amusement from social functions and always shunned them. His impediment brought about a defense mechanism in the form of a snobbish reserve which discouraged strangers from being friendly with him; consequently had very few friends, but those he had he valued very highly and considered them a great comfort.

His married life was peaceful and happy so that his speech impediment lost a great deal of its depressing weight. His wife attended to all matters necessitating speech on his part. He noticed that trivial events disturbed him while serious ones had the opposite effect. His thoughts and imagination affected him more than actualities; for example, anticipatory speech situations or happenings put him in such a state of unusual excitement or fright that he would become very weak, experiencing a spent feeling in the pit of his stomach, a mad quivering and throbbing within him, and a feeling that death was imminent.

On the other hand, when in actual danger he never experienced fear or panic, only a mild excitement; for instance, he was unfortunate enough to be in a number of accidents. In the last one he was hit broadside by another car and while his car was turning over had the presence of mind to turn off the ignition. On crawling out from under he felt no effects of fright or shock. Incidentally the other driver, safe and unhurt, could not speak for some time.

He had periods of depression being gloomy and dejected, mulling over his speech troubles and disappointments, magnifying them until he was quite miserable. However, when successful in speaking, saying what he wished to say in just the way he wanted to say it, he becomes intensely happy, radiating cheer and good will, bursting into song and so forth, and as he aptly put it, "I'm in love with the whole world." He also stated, "When I am alone in a room, when I am positive no one can hear me—not even a cat—I can recite, read, and indulge in plain and fancy talking with no difficulty at all. If I get very angry I can argue without any trouble whatsoever in my speech."

His initial interview at the clinic made a strong impression on him. The rebuilding of his personality was commenced at once. His physical examination did not reveal anything

of a special nature. A scar on the back of his head and on his cheek was the result of an accident. There was no apparent influence following it on his health or speech. His I. Q. was 90. He demonstrated his lack of emotional control in many ways. His stuttering speech recording showed long pauses between words. During these pauses there were contractions of the facial muscles and lateral movements of the lower jaw. He also complained of tenseness of the abdominal muscles while trying to speak.

The composite therapy of our Medical-Social Clinic influenced his chronically exaggerated emotional status and his response to treatment was most gratifying. Integration took place and his vital personality traits were placed in their proper relationship. His periods of depression and exaltation became less and less as soon as some of the underlying chain of causes were discovered and eliminated. For the first time in his life he came to appreciate a spiritual peace which is ever present in our specially created atmosphere. His non-social habits, his feelings of inferiority, were gradually influenced. Our open-door psychiatry was very beneficial in his case. It made it possible to call in other patients during discussion, thus eliminating the personal aspect of secret problems. H. G. realized that these problems were not his alone but part of the stuttering fraternity as a whole. Many minor emotional disturbances were thus resolved. A few closed door interviews brought under control various unconscious difficulties. Social therapy brought further adjustment. He participated in the affairs of some of our clubs, which acting as outlets, normal self-expression becomes a matter of course.

After a period of time, his psychological reconstruction and emotional control brought about a complete change in personality. Social conflicts, fears and failures, became a thing of the past and with it his stuttering speech also became a thing of the past.

Case III. C. L. A stutterer, 42 years old, occupation a draughtsman, married. Referred to the clinic by an out-of-town hospital. There was no trace of stuttering in the family on either side, although his mother was of a highly nervous type. His stuttering commneced at the age of five, following an attack of whooping cough. His initial interview was a very labored affair for he had practically nothing to say. His wife, who accompanied him, answered all questions. Finally he wrote out the following statement:

> In my thirty-seven years of stuttering I have attacked my problems mentally from many angles, hoping that I would find a way out. Many questions beginning with the word "How" entered my mind, and received my earnest consideration, but in arriving at a conclusion it is clear now that I evidently did not use enough of that rare element called "common sense" to find the logical answer. Therefore, quite a few years ago I concluded that stuttering speech was just a part of me, probably a birthright, and nothing much could be done about it. I, therefore, decided that my next step would be to effect a compromise with this undesirable "gift" and at least try to live peacefully with it in the same house. Forthwith I selected a vocation in which I thought speech would be minimized and I arranged my social life so that speech would cause me but little embarrassment. Similarly my hobbies were such that I spent most of my time alone or with some person who did not seem to mind my stuttering. In other words, I adjusted my life to fit a situation, which I believed could not be changed. Still I often wondered and asked myself these baffling questions—"How did I ever get into this awful condition? How can any human being who is otherwise sound in mind and body become so helpless as far as speech is concerned?"

These questions and many others were answered during the interview. The very things which he had been doing all his life to avoid the issue were the vicious practices that stood behind his fear and emotional instability with its physical protest of stutterng speech, or in his unusual case, no speech at all.

C. L. presented an intense, drawn, sorrowful expression. On examination he was found to be physically fit. Intellectually he was above the average. The recording of his speech proved most interesting for the entire record has but two words and a few inarticulate sounds, interspersed with long periods of silence. The noticeable thing during his recording was movements of the lips without vocalization due to a spastic condition of the vocal cords, also a general muscular rigidity. It was impossible for him to show any relaxation until long after the speech test. His special therapy was self-evident. Relaxation took

first place while reëducational therapy was secondary.

Through a series of relaxation exercises he gradually came to appreciate the difference between his former tense state and his present relaxed state. His mind and speech were made quiet and tranquil and he found to his surprise that he was really saying things. He was gradually developing a feeling of ease throughout his entire being, which gave him a feeling of comfort and security.

Through years of isolation his life had become one of introversion, repression and frustrated desires, in fact, his adult personality was so warped that his infantile attitudes and conflicts remained with him. Careful consideration and sympathetic understanding brought about changes and clarified the underlying chain of causes.

Direct and indirect suggestion therefore played an important part in influencing a change of viewpoint. His personal assets were strongly emphasized to counteract his extreme feelings of inferiority. Many conferences were devoted to the solution of his emotional conflicts. His "compromise" was only a mode of escape. Gradually a restoration of faith in his ability was brought about. Our reëducational therapy made him thoroughly capable as far as his speech was concerned. He finally realized the normalcy of his vocal tract, which definitely proved the futility of his compromise.

Social therapy with its special elimination of the fear of social contacts proved very effective. The club life at our clinic was for many years the first outlet he had for self-expression and the chance to cope with oppositional environment. He soon developed a feeling of social security. Speaking normally to individuals and before groups has now become a natural procedure. His present happiness overpowers the recollection of his former failures.

To conclude—the following ideas are offered for consideration. The stutter-type is one born with a highly emotionalized organic structure. His organism as a whole must be considered of peculiar intimacy with the environment. His condition is one of uncontrolled emotions, fears and failures, developing into an anxiety or fear neurosis. Primarily the problem is one of personality not just defective speech. The individual and group treatment as developed in our clinic has proved practical and efficacious for the integration of the personality and the elimination of the speech defect. It is of a composite nature—medical, psychological, psychiatric, reëducational and social therapy.

Our Medical-Social Clinic for the treatment of emotionally maladjusted individuals—the stutter-type—is the clinic of the future and has proved an absolute necessity as a Public Health Service.

INTRA-OCULAR NON-MAGNETIC FOREIGN BODIES WITH SPECIAL REFERENCE TO THEIR REMOVAL

By George H. Cross, M.D., Chester, Pa.

Read on May 2, 1935, before the Section on Eye, Ear, Nose and Throat at the 169th Annual Meeting of The Medical Society of New Jersey

It has been truly stated "the world is constantly changing". Ophthalmology keeps apace and changes too.

When Hirschberg invented the electric magnet in 1877, it was thought that the troublesome question, the removal of a foreign body in the eye had been solved. Industry has changed our ideas, with modification of the character of cutting tools and the various types of metals that alter and take the place of steel. We now almost have to be a metallurgist or a chemist to know the character and magnetic attraction of foreign bodies that enter the eyeball. The efficiency of cutting tools has been increased ten times by the use of tungsten carbide with cobalt matrix and some firms use a combination of tungsten and tantalum. Steel containing 18 per cent chrome and 8 per cent nickel is used where heat resisting and erosion resisting conditions are to be met.

Rails for street cars contain 10 to 14 per cent manganese. In addition to these types of steel that are non-magnetic, we now have to contend more and more with the use of other types of metal, lead, zinc, tin, brass, copper, aluminum, manganese, tungsten, cobalt, monel metal, allegheny metal, and many others non-magnetic in character.

A careful history showing the occupation of the patient and the character of the material he was working with when injured is of great assistance and importance in determining our method of procedure.

There are many instances on record where non-magnetic foreign bodies have been removed by grasping the foreign body with a pair of forceps through an incision in the sclera, while observing its location in the vitreous with an ophthalmoscope.

Dr. Frank E. Burch of St. Paul, Minnesota, in a personal communication 1932, reports the removal of a piece of copper 4x2 by ½ mm., from the left eye of a woman injured in a dynamite explosion. He saw the copper in the vitreous with an ophthalmoscope. Following an incision in the sclera just below the internal rectus muscle, he inserted the wire loop shot forceps, guiding them with the ophthalmoscope he successfully removed the copper.

There are numerous cases recorded where the foreign body could be seen through an incision in the sclera, after an accurate localization determined its position. These were also removed with forceps, while viewed directly through the incision as related by Friede; *(Removal of non-magnetic foreign bodies from the vitreous. Klin. M. f. Augenh., 1933, V90, March, p. 368.)* Two cases are reported in which the foreign bodies after localization with roentgen rays and direct illumination were extracted through an equatorial incision between the ciliary body and ora serrata, the best place for avoiding detachment of the retina. The advantages of equatorial section as against the meridional section near the foreign body as devised by Haab (by which in the second case the foreign body could not be reached) are emphasized."

Prior to 1926 the usual expression of opinion regarding the procedure in these cases is well stated by Haab:—"It is often more advisable to leave them in the eye (unless of course, they can be seen somewhere in the anterior segment of the globe where they are accessible), than to open up the vitreous and probe around, as it were, in the dark, with forceps and other instruments in search of the foreign body. To endeavor to remove such oftentimes damages the eye more than to leave it untouched."

Case 1. On November 13, 1924, Mr. J. W., aged 71, was admitted to the Chester Hospital with a history of having been shot in his left eye the preceding day while gunning for rabbits. At that time I made an attempt at removal of the lead shot, after devising an instrument made by drawing the temper from a long steel needle, making a round loop in the end the same size as the shot, beveling it so that a lead shot of that size would fit it nicely. I also made one of brass wire with the looped end bent at an angle, this would not work, as it was too long, and interferred with the fluoroscope, at the same time offering greater possibilities of injury to the eyeball. At that time the effort was made to see the shot and the instrument with a single plane fluoroscope and an attempt was made to get under the shot and lift it out with this ring. We were unable to see the position of the instrument and the foreign body; and as the density and character of the vitreous interferred with the sense of touch, our method proved a failure.

Case 2. On November 12, 1926, Mr. J. B., aged 51, while hunting rabbits was struck in his only good eye by a number six lead shot. The history showed that his other eye had been removed about 30 years previously by my father, following an accident while he was employed in a machine shop. In this case you see we were confronted with a lone eye in which there was a lead shot in the vitreous and no worry about sympathetic ophthalmia. Recalling the experience in the preceding case and its failure, I hunted about for other means to attempt the removal. The thought came to my mind that if a proper instrument could be devised which required a minimum opening in the eyeball to permit its full action that possibly the shot could be located by the biplane fluoroscope and grasped by an instrument without causing too serious damage to the structures of the eye. Following this thought a pair of cross action forceps were made of German silver wire with ends bent in the form of a circle of a size to take the number six lead shot.

The attempt at removal of the shot from the eye of Mr. J. B. was made on November 12, 1926. Guided by the expert ability of Dr. Willis F. Manges, the roentgenologist of Jefferson Hospital, Philadelphia, who was able to see the shot and

the forceps with a biplane fluoroscope, our efforts were crowned with success and the pellet of shot removed. The vision before the operation was only L. P.; and while the damage we did was not severe, Mr. J. B. failed to recover any vision.

As our experience grew with this type of case quite naturally our method varied to suit the change in conditions. Before attempting the removal of a non-magnetic foreign body careful x-ray localization must determine its size and position, as the foreign body must be sufficiently large and dense to throw a shadow on the plane of a biplane fluoroscope. The patient must be referred promptly to the surgeon before nature has time to encase the foreign body with exudate. All instruments must of necessity be short to allow a close approach of the fluoroscope plate to the eye, this greatly increases the ability of the operator to see the foreign body shadow.

METHOD OF REMOVAL

The patient is placed on the fluoroscopic table and prepared as for any major ocular operation. Anesthesia is of great importance. Our success has been much easier and the length of time required considerably shortened since we have routinely used in addition to local surface anesthesia retro bulbar injections of one per cent novocain which prevent the rolling of the eyeball. Previously when we used local anesthesia and the Van Lint method of blocking, the patients, while in a highly nervous state, would change the direction of their vision, which frequently upset the operator's ability to grasp the foreign body.

An opening is made in the conjunctiva with scissors and a black silk suture placed in either side to hold the edges apart and permit easy access and a clear view of the sclera.

The incision is now made in the sclera in an equatorial direction about 6-7 mm. back of the limbus so as to enter between the limbus and the ora serrata; and centered at 12 o'clock, a slight right angle incision about 2 mm. long is made in the posterior scleral edge to permit ease of removal of the shot forceps with the contained foreign body. This type of incision is less likely to produce a retinal detachment later on. In making the scleral incision, care must be used to penetrate just through the sclera and not too deeply, in which case we would stir up vitreous unnecessarily. Dr. Edward Stieren of Pittsburg has devised an instrument called a *scleratome* to be used just for this purpose.

The wire loop shot forceps are introduced, closed, through the incision in the sclera and opened so the looped ends are in the approximate position of the foreign body. The lights are now turned off and the fluoroscopic operator looking at the forceps and the foreign body in two planes directs the surgeon to move the forceps so the fenestrated tips will be guided to the correct position and closed to grasp the foreign body, which will remain in the forceps as the cross action serves to hold it firmly and tightly.

The lights are now turned on and the forceps with the foreign body are withdrawn from the eye. An applicator moistened with carbolic acid is applied to the edges of the incision to increase the amount of exudate formed and hold the tissues in a firm scar. Then one or two sutures are placed in the conjunctiva, atropine is instilled, and the eye bandaged.

We have operated by this method on eighteen cases with the foreign body definitely located in the eyeball and have succeeded in getting the foreign body every time. The last case, one referred from Washington in January of this year, was most unusual in that in one eye there were two pieces of brass about 2 x 4 mm. which were successfully removed.

It is only the exceptional case that does not react promptly to the presence of a retained foreign body, and generally so by producing inflammation. A quiescent case is never certain to remain so, but may suddenly flare up without warning and cause total destruction of the eye. As long as a piece of metal remains in the eye, there is always the risk of acute cyclitis. Leber's researches as to the origin of inflammation demonstrated that purely aseptic foreign bodies do not remain unchanged in the eye. There is an almost constant chemical reaction taking place following the solution of the foreign bodies by the intra-ocular fluids and the migration to various tissues.

DISCUSSION

Elbert S. Sherman, M.D., Newark: Dr. Cross is to be congratulated on originating and developing this very important contribution to ophthalmic surgery, and on his skill and success in its use. To enter the vitreous with an instrument is always, even under the most favorable conditions, a hazardous procedure; and so it is not surprising that Haab's advice concerning non-magnetic foreign bodies was, "It is often more advisable to leave them alone than to open up the vitreous and probe around in the dark with forceps and other instruments in search of a foreign body." Such treatment is usually destructive to sight and often to the eyeball itself.

Dr. Cross's forceps, adapted to the size and shape of each individual foreign body, used with the invaluable aid of the biplane fluoroscope, and the rest of his technic including a retrobulbar injection, which is very important, reduce these hazards to a minimum. However, the dangers inherent to removal, even with this improved method, must be very real, and are probably greater in some cases than if the foreign body were left alone.

We all agree that a retained intra-ocular foreign body is forever a menace to the eyeball; and when it can be removed without further serious damage to the eye, this should be done very promptly.

A delay of twenty-four hours may, in some cases, change the prognosis for the worse. However, there are many records of cases in which an intra-ocular foreign body has remained quiescent for years. I have personal knowledge of several such cases. Small foreign bodies particularly, often become encysted and remain so. Degenerative or nutritional changes may or may not, in time, destroy the sight, but in many cases a similar but earlier result would have followed a difficult removal of the foreign body.

The following case history is an example, but an unusual one, I admit, of the tolerance of an eye to a retained foreign body:

In August, 1922, while standing near a blacksmith's forge, a young man was struck in the left eye by a piece of steel. When I saw him the next day, there was a perforating wound near the center of the upper lid; and beneath it, about 5 mm. from the limbus was a linear wound 4 mm. long through the sclera. The vision was 10/200. After dilating the pupil, which was normal, a fairly large mass of flocculent material could be seen deep in the vitreous and temporal to the disc, in which was a bluish white object which was thought to be a foreign body. A roentgen examination revealed a foreign body 4½ mm. by 7½ mm. in size, 17 mm. posterior to the center of the cornea at approximately the location as seen with the ophthalmoscope. Repeated and persistent use of magnets, including the Haab magnet, failed to move the foreign body. It was never determined definitely whether the object was non-magnetic. It was thought to have come from a hammer. I examined this and found that it was strongly magnetizable.

At no time was the eye severely inflamed and six weeks after the accident it was perfectly quiet and remained so. I examined the eye in 1934, over eleven years after the accident. There were then cortical opacities in the anterior and posterior parts of the lens through whic hcould be seen an ill-defined dark area in and in front of the lower part of the retina. The eye was quiet. The vision was 5/200. There was no siderosis bulbi. In a case of this kind I believe that forceful removal of the foreign body by entering the vitreous with forceps or other means would have been disastrous.

For a long time we have been taught that while lead and glass are better tolerated than most substances, copper is most dangerous. There are, however, many exceptions, as illustrated in the following case:

In April, 1934, a thirteen-year-old boy caused a percussion cap to explode. Several particles of copper were embedded in the skin in various places, and one piece perforated the sclera of the left eye 3 mm. temporal to the limbus.

When I saw the eye three days later the wound of entrance was closed and the eye was quiet and painless. A small dark mass and some small opacities could be seen in the anterior part of the vitreous on the temporal side. The uncorrected vision was 20/30. The roentgen examination showed a foreign body 2 mm. by 2 mm., 10 mm. back of the center of the cornea temporally. Noninterference was advised. The eye has remained quiet.

On April 30, 1935, the ophthalmologist in a neighboring town who referred the case to me examined the eye, and could see the foreign body lying on or in an atrophic spot in the retina. The vision with a small myopic correction was 20/20. The eye was quiet.

These cases are, of course, exceptional and are not cited as an argument against removing every intra-ocular foreign body which can be removed safely. By that I mean without undue risk of causing greater damage than could reasonably be expected to result from the retention *in situ* of the foreign body.

According to Weeks, toleration of a foreign body depends on a number of things: First, the nature of the foreign body; second, size; third, location; fourth, whether it is aseptic; fifth, its chemical composition; and sixth, whether it becomes encapsulated or remains free.

Before deciding to enter the vitreous to recover a foreign body, I believe these factors should be carefully considered, and to them I would add the length of time the foreign body has been in the eye, and the amount of damage already done as a result of inflammation or trauma.

Removal of a foreign body from the vitreous does not assure the preservation of vision or the safety of the eyeball. The trauma caused by the foreign body when it entered the eye or that caused by its removal—rather than the effect of the foreign body itself—is more often the cause of such subsequent events as acute or chronic iridocyclitis, panophthalmitis, sympathetic ophthalmia, or complicated cataract.

THE ESSEX COUNTY MEDICAL SOCIETY

By John F. Condon, M.D., Retiring President, Newark, N. J.

The President's Address at the Annual Meeting of the Essex County Medical Society on October 10, 1935, in Newark, N. J.

My acceptance of the honor and responsibility of the presidency of the Essex County Medical Society a year ago carried with it a pledge that I would attempt to carry out the highly constructive program which my resourceful and energetic predecessor, Dr. E. W. Sprague, was endeavoring to complete in the interest of Organized Medicine and the public at large in Essex County. This evening, upon relinquishing office, it is pertinent and expected that your retiring President show that he has made every effort to sustain that promise.

CONTINUATION OF COMMITTEES

At the outset, facing this grave responsibility with more or less temerity, it occurred to your President to break away from the precedent of naming new committees. Those of the previous administration, led by chairmen of proven ability, and the addition of those members of the Society who expressed a desire to serve, and also others who were recommended for their interest and experience concerning the important problems that required sound reasoning and mature judgment, were asked to serve for another year. Recalling, as you will, the committee reports of this year, you may agree with your President that their continuance was well founded. At no time did the committees anticipate that their efforts were to be crowned with complete success in endeavoring to unravel the many difficulties of their administration, but their desire was to accomplish the utmost in the limited time at their disposal.

SCOPE OF COMMITTEE WORK

Referring again to the reports, you will concede that a multitude of questions have been painstakingly examined and presented in a concise form for your consideration. For the information of members who have little knowledge of the time devoted and energy involved, the following statistics have been compiled:

Fourteen Council meetings, with a majority in attendance;

Forty committee meetings, with a majority in attendance;

One hundred per cent attendance of your delegates at the Annual State Convention. In contrast, only ten to forty per cent of the members attended the seven general Society meetings.

The presentation of these figures is for the sole purpose of demonstrating the apparent lack of interest of many members in the important phases of Organized Medicine in our County, and is made for their own benefit as individuals. The quotation that "Every chain is as strong as its weakest link" is of significance here.

This Society and its individual members are under profound obligations to the chairmen and their committees, who with great personal inconvenience, many hours away from their practice and recreation, have labored hard not only in our behalf, but also for the public whom it is our privilege and duty to serve. They have not been just progressively active in the evolution of sound medical principles, but in some instances they have blazed new trails of broadened activities.

STANDARDS MAINTAINED

Here permit your President to pause and express his sincere gratitude for the loyal support these men have extended to him during the year; and likewise, for the splendid cooperation of your Council and many members of the Society.

Furthermore, and exceedingly important, not only have they devoted their attention to the several perplexing problems under consideration, but also, have at all times stood as watchful sentinels at your portals, ever alert and ready to defend you and your organization against unwarranted invasion by political, bureaucratic, and pseudosocial meddlers, whose unsound and undemocratic principles your leaders have stubbornly resisted.

Any movement, whether social, institutional, municipal, county, state or national in scope, that in any way attempts to disturb or destroy the physician-patient relationship, must be met with unflinching opposition by Organized Medicine. Success in Essex County imposes a major obligation upon us all to wholeheartedly support our officers during the coming year in meeting the responsibilities we ask them to assume in our behalf.

It cannot be too emphatically stated that the desirable time and place to offer constructive criticism of policy and to present propositions for discussion is at the Society meetings. Staff rooms and hospital corridors offer no advantages, and are frequently the scenes of ridiculous arguments resulting in faulty conclusions and gross misunderstandings.

JUNIOR AND SENIOR MEMBERSHIPS

In connection with this, your attention is called to Article II of your Constitution. In part, it states:

> "The purpose of this Society shall be to organize the licensed physicians and surgeons of Essex County who hold the legal title of Medical Doctor and are eligible to membership, for the strengthening of professional bonds and friendly relations among the members and to their mutual benefit and economic welfare."

In directing attention to this Article, which seems to be the keystone in the arch of the structure, is to stress the fact that it makes no reference to senior group or junior group, nor does it mention race, creed, or nationality; but in true American and democratic spirit, refrains from any such classification. Article III, under eligibility, only demands United States citizenship; Article V pertains only to honorary members.

In view of these facts, may your President ask why the unconstitutional movement to segregate the Society into junior and senior divisions?

From its inception, the movement has had your President's strong opposition, and he earnestly requests that you join with him in that opposition on the very firm grounds that it is unwise and unnecessary, and is a dividing wedge which will insidiously destroy the sound principles of the Constitution of the Society by falsely classifying the privileges, advantages and responsibilities of one group as distinct from the other. The genesis of this movement, to put it charitably, was imaginary grievances. Here are some of the grievances and demands:

1. That the younger men should have representation on the Council.
2. That the domination of the Society is in the hands of older men, not in sympathy with the young men's problems.
3. That floor privileges at our meetings are not open to younger men.
4. That a large membership of the Society of a foreign nationality should have representation on the Council by a member of that nationality.

To test the validity of these grievances, a Grievance Committee was appointed one year ago. A member of the Council was selected as chairman, and the membership was limited to men practicing less than ten years. The few cases presented to the committee for action in no way involved questions of privilege or restrictions in this Society. It is suggested that this committee function for another year, and if the demands are as few as they have been during the past, the committee will dissolve as unnecessary.

HIGH ETHICAL STANDARDS

To the esteemed credit of our membership is the gratifying and outstanding fact that your Ethics Committee has not been appealed to with the few exceptions when newspaper publicity or department store advertising were involved. These instances were promptly and efficiently dealt with. No member of this Medical Society has been officially pronounced unethical during the past year. In this connection also, the E. R. A. practice has been conspicuous for the honorable conduct and cooperation of the medical profession of this County, with very few isolated exceptions.

The references to these various items of the closing administration is an attempt on your President's part to sustain his pledge when he assumed office. If he has not done so, then your are obliged to charge it up to the fact that the Society, in selecting him, reversed its sound philosophy by "honoring the

man, instead of the office by the fitness of the man".

As a final message, may your President be permitted to present for your consideration a few propositions which appeal to him as having some important bearings upon the welfore of this body.

DISCIPLINE

First, it is recommended that Section I of Article 7 of the By-Laws relating to *Discipline,* be carefully studied with the intention of inserting teeth in it that will remove the name of any member from the roster, who, after a careful and impartial investigation, is found guilty of conduct, professional or civic, that is inimical to the interests and reputation of a member or the Society as a whole. The reason for this receommendation is that we have ample means to protect us from such individuals becoming members of the Society, but appear helpless in dealing with those, who already members, are guilty of violating our codes.

PROGRAMS

Second, it is recommended that the County Society limit its program of the general meetings to the consideration of topics which relate solely to the mutual benefit and economic welfare of our members, the Society's interests in Organized Medicine, and the public welfare of this community. That all scientific programs be referred to the various sections of the Academy of Medicine for their presentation to the profession and to the public. That this recommendation be considered by a joint committee of the County Society and the Academy of Medicine, and be referred to the Council for final action.

DISTRICTING THE COUNTY

Third, that the incoming President, Dr. A. C. Zehnder, appoint a commission which will make a survey of Essex County for the purpose of determining the advisability of dividing the County into districts with each district having representation on the Council, instead of the present system of representation; and that this commission, after careful consideration of the proposition during the year, report its findings and conclusions through the Council to the Society at next year's Annual Meeting.

The reasons for submitting this proposition are, that Essex County has twenty-two municipalities; that it covers a very wide area; that there are 1100 physicians practicing in this area, or about forty per cent of the total membership of the State Society; that medical problems may have different phases in different districts; finally, that by representation in the Council from each district, mutual understanding and coöperation by the whole Society would be greatly enhanced in the interest of Organized Medicine in Essex County. As a precedent in organization, we have the American Medical Association divided into states, and states into counties, with proportional representation in each.

PENSION FUND

Fourth, that a commission be appointed to study the question of establishing a pension fund for members of this organization, who by reason of advanced age or physical disability, are unable to practice their profession, and who after satisfactory investigation are found unable to procure the necessary comforts of life for lack of sufficient means. That this committee study and familiarize itself with every angle of the proposition for a year or two, and then report its findings at an annual meeting.

The late Dr. Kipp inaugurated a fund for the widows and orphans of medical men.

Last year, the Society set up machinery for the purpose of aiding members in financial distress. Would this not complete our welfare program? Other organizations have successfully established such a fund—why not Organized Medicine?

In conclusion, your President wishes to express his deep appreciation for having been honored by you with the office of President; and to solicit your earnest and enthusiastic support of his successor's leadership of the Society, for the Society, and by the Society.

THE UNION COUNTY MEDICAL SOCIETY

By Edward S. Krans, M.D., Retiring President, Plainfield, N. J.

The President's Address at the Annual Meeting of the Union County Medical Society, October 9, 1935.

The County Society is the functioning unit through which the medical profession must work out its destiny. Let us ponder over this fact for a moment, for by so doing its accomplishments will arouse in us a respect bordering on affection.

The Union County Medical Society came into being by virtue of a commission granted by the Medical Society of New Jersey on May 26th, 1869, soon after the county was set off from Essex County. There were fifteen charter members. According to custom it adopted a Constitution and By-Laws, and elected a secretary, a treasurer, and a president—a unifying, directing officer to preside, execute its will and carry out its functions through proper officers and committees. This skeleton grew in stature, padded with a healthy membership, and animated with a friendly spirit. Of course there were outbursts of rampant individualism and moments when cliques ruled, demanding an automatic acquiescence from the majority for a brief while; but such extremes have been resolved by an *esprit de corps* that fused all differences in a cauldron of mass thinking out of which a common purpose emerged and works ultimately for the common good.

UNITY OF PURPOSE

A medical society to most of us used to mean a meeting now and then at which a paper was read and discussed, after which, those so inclined loitered awhile to eat a sandwich, and have a chat. Of course, we realized that the local society was part of the State Society and one component of a mammoth parent, the American Medical Association, that sent us a weekly journal, and got up yearly a big meeting that we attended a few times during our professional careers. However, there were men who envisioned a staunch bulwark behind which some day the profession might stand if danger threatened; but danger was a meaningless word in the days before the World War, and those who hinted that we might have to fight for our rights seemed merely a lot of hotheads like the jingoes of nineteenth century politics. These far-seeing men were the same, or were of the same fibre as those who struggled for helpful legislation, for a medical practice act, smallpox vaccination and provision for the tuberculous, for sanitation, for safe-guarding milk, for proper school inspection, and for laws checking quackery in all its modern forms, and besides they secured economies in insurance and made provision for legal aid in malpractice suits.

However, other things faded into the background during the lurid days of the War, and were forgotten in the gala time that followed, when money flowed like water, and the people danced without a thought of who would pay the piper. But alas! when hands began fumbling in empty pockets, and when money-lenders would lend no more, then the medical profession suffered as nearly all professions, businesses, trades, and groups of laboring folk also suffered; and in its need, and time of uncertainty, the craft foregathered within that bulwark, so strongly set up of yore, and took counsel how the emergency might be met. The same thing happened in every county, from north to south, and from east to west; and, when all was said and done, it was a surprise to learn how much had been foreseen, how many economic experiments had been tried, and how many more had been studied. Then the threat, implicit in the social security legislation pending in Congress, roused the profession, as with a pistol shot, and a metaphorical Paul Revere clattered through county after county spreading the alarm—"Doctors to arms! Socialization is upon us." Whereupon, whether unduly frightened or not, nevertheless, with laudable zeal, physicians drew together and became, as never before, a united profession with a common purpose.

ECONOMIC SURVEY

In Union County, the new spirit was first evidenced in a survey of medical economic problems by a committee so large that it was representative of the whole membership. Its various sub-committees worked in detail each upon a special topic, and the result was a mass of material that gave us a broad view of our economic problems, and that can be drawn upon as needed from time to time. The two economic subjects considered at once were *Emergency Relief*, taken up of necessity because of the impoverished condition of the people, and the *Public Health Hour*, a laudable effort to bring back to private physicians the immunizing service that has been rendered by non-professional agencies, many of whom did it on a cut rate basis, both as regards the service and the pay of the doctor who actually did the work. Of course, the only sane solution of this question is legislation requiring immunization against specified diseases, as has been done with smallpox vaccination.

A lesser performance, but important if followed up, was the reminder sent to all hospitals in the County in regard to the abuse of free clinics, that resulted in a falling off in free cases, including those formerly sent by the E. R. A. Besides a repetition of the reminder, there must be a change in the methods of hospital social service, such that it furthers the interests of physicians as well as of hospitals.

THE PATIENT OF SMALL INCOME

The greatest problem facing us today is that of caring for persons of small or moderate income in a way that supplies their necessities, and at the same time gives the physician a fee that is a fair remuneration for the use of his time and skill. It should always be kept clearly in mind that this service must be rendered in one of two ways: either by lay authority, presumably governmental, hiring or, in some way, remunerating doctors on commercial lines; or by voluntary organization of the profession to meet this social need, as well as to safeguard the right of the patient to choose a physician, and to preserve our pristine standards and traditions. In this dilemma there is only one choice,—the profession must keep its cherished freedom and be governed by its own strictly observed code. Now unfortunately the opinion is gaining ground that the plan for socializing medicine has been dropped because it was not taken up by the past Congress, but this is not true, and the subject will be again brought up before this Administration is out of the saddle. Consequently, no time should be lost in preparing for the crisis in our affairs; for, while the utter ruin predicted by alarmists will never come, it would, nevertheless, be a great misfortune if medicine alone was socialized. If socialism is a good thing (which is doubtful), then everything should be socialized; but it will not be, for the trend that way in this country will go no further than the regulation of industry, finance, and labor that has become necessitated because of the misconduct of capitalism.

THE WASHINGTON PLAN

The various schemes that have been suggested in place of socialization were admirably summarized last year in the address of Dr. W. B. Morris, the retiring President of this Society (Jour., Nov., 1934, p. 642); but, since his paper was read, an experiment that was being tried in the District of Columbia has yielded results so good that it stands out as the ideal plan. (Jour., Oct., 1935, p. 618.) It is under medical control; it is fair to the patient and fair to the physician; it pays its own way; it lets the patient choose the doctor; and above all it is free from the deadly poison of the profit motive. The details of this Washington Plan have been studied, and it is hoped will be presented to the Society at the next meeting.

EDUCATIONAL FUNCTIONS

Scientific affairs, in the nature of things, occupy us largely. The County Society is the local medical profession, and to it come specialists and research workers to tell of their adventures in fields remote from the general world of medicine; and not only is this good for our instruction, but it also serves as a check on the exuberance of theorists, and of ultra-academic professors, inasmuch as they must justify themselves before a tribunal of common sense

developed under the exigencies of everyday practice in office and home.

To the County Society may also come commercial houses of good standing to demonstrate their wares and instruments, representatives of other professions and of public and private philanthropies to present subjects related to health, to doctor, to patient, or concerning the welfare of the community.

The Society supports the post-graduate courses arranged by the State Society insofar as they are of use to the individual, giving them preference over similar courses in metropolitan schools. Furthermore, aside from promoting these educational facilities, there is a sort of training that comes through sharing in the life of the Society, so that the older men, without assuming the rôle of pedagogue, may impress the younger by bringing them quickly into the thick of current activities. The newer members should be put on committees, or made alternate delegates, or given something to do at once after admission; and as a matter of justice, if courtesy is not reason enough, the women should share equally with the men.

CIVIC DUTIES

Each member of the county group has civic duties to perform. For instance, a few doctors should interest themselves in politics, as have others of former generations, such as James S. Green, who was first President of the old City Council of Elizabeth; Dr. Stillman, who was Mayor of Plainfield and founded its Board of Education; and later Dr. Mravlag, who seemed for a time to have become Mayor of Elizabeth *in perpetuum*. Physicians occupying such conspicuous positions are willy-nilly representatives of the County Society, and their views and actions are generally so considered, even if unofficial; and for this reason, it would be a good plan, when feasible, to have the more important places filled by appointees of the County Society. At any rate, membership in the Society is a guarantee to the public that a physician is properly qualified to practice, is ethical, and is not a quack or exploiter. Therefore, this Society quite properly has the right to purge itself by the expulsion of those whose words or acts are derogatory to the good name of the profession. To do this at present is difficult, and changes in the Constitution and By-Laws should be made that would insure a method of effective discipline.

LEGISLATION

Another function and important duty of the county unit is to coöperate with the State, when it acts as watchdog of legislation. The present policy of exerting pressure on Senators and Assemblymen, through key-men in each neighborhood, is best carried out through the County Society, because it not only is in position to select the right persons, but also because it can call upon the Professional Guild of the county to help. This Guild, formed in 1921, and resuscitated in 1934, unites nurses, pharmacists, dentists, and doctors for political purposes. If every county were similarly organized, the united voting power would be such as to prohibit harmful legislation. However, participation in the Guild involves reciprocal obligations, and we, in turn, must help our associates in their hour of need. Now, of course, the character of legislative activity varies, but there is always present both the need for keeping in touch with legislators and for making sure that our State Legislative Committee and Executive Secretary keep constant vigil.

ETHICS

Passing on to another phase of our corporate existance, and one that is vague yet often evoked by quite concrete events, there remains the subject of ethics. Ethics often seems best left in an iridescence of uncertainty, because it depends largely on circumstances that change with the shifting sands of time. Behavior cannot be measured by the yard, and motives are as difficult to handle as fog or sunshine. The palpable aspect has been well considered in Principles of Medical Ethics, published by the A. M. A., a pamphlet that should be read by everybody, and that is good in the field of formal ethics; but it never leaves firm ground and fails to cover the personal problems that so often are encountered in prac-

tice. Take, for instance, the case of a supposed criminal who seeks aid of a physician for a wound or illness. Should the doctor hand him over to justice? Naturally the physician is as obligated to secrecy in giving comfort to the body as is the priest in giving peace to a tortured soul; but after trial, if the applicant for help has been adjudged guilty, and has escaped, the situation is different, for his guilt has been determined, and he is a refugee from justice.

Again, suppose a young girl who has lapsed from virtue confides in her doctor. What is his duty to her parents? Such questions tax the ingenuity of an experienced casuist, and while each has to be settled on its merits, yet there are general principles that can be laid down, and a book covering this ground discursively and not didactically would have great value for young physicians.

Then in the field of ethics, but rather a personal matter, is the sort of therapeutics we practice. Sometimes it seems as if transfusions and intravenous medications were done rather promiscuously, and that it would be well to wonder, with Paul White, if possibly the increase in variously located thromboses may be related to these procedures—to say nothing of bills piled up against those who can ill afford them. In these personal matters the County Society should not meddle, nor should it go into minutiae of conduct, but rather avoid a too large supervisory function, seeking only to maintain general standards as specified in the Principles of Medical Ethics.

FRATERNALISM

In this discussion of the functions of our Society emphasis has been laid on moral values, goodwill, and proper motivation that too often are hidden in the background of the mind. It is these qualitative things that have made the medical profession a *fraternity* without secrets or passwords. Our uniqueness in this respect has made us conspicuous, and the closeness of our professional bond has made us strangely responsible one for another; and this fact is so widely recognized that the world at large assumes that what one doctor does or says is representative of the craft as a whole; and this in turn gives the same uniqueness to our Society in which our interests converge, and from which emanate our lines of conduct and our policies.

THE ACADEMY OF MEDICINE AND THE DOCTOR

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

The Address of the retiring President of the Academy of Medicine of Northern New Jersey, delivered on May 16, 1935, in Newark, N. J.

The Academy of Medicine of Northern New Jersey was organized for the advancement of the science and art of medicine, the maintenance of a public medical library, and the promotion of public health and medical education.

In 1931, Dr. John Hartwell, Director of the New York Academy of Medicine, presented a paper before the Fifth Councilor District meeting of The Medical Society of New Jersey, which was published in The Journal of The Medical Society of New Jersey (August, 1931, p. 639). The title of his paper was "The Continued Education of the Doctor". This appealed to me strongly, and it is the thought I wish to bring to you.

HABITS OF STUDY

A doctor graduates from a medical school; and after spending a year or two, or more, in hospital work he settles down to practice his profession. While waiting for his practice to grow, he is bound to form certain habits. Is he going to continue his studies; or is he going to spend his spare time reading detective stories, attending the movies, or playing bridge?

If he spends much time socially, he not only gets his mind off his work, but is inclined to slight it in order to keep his social engagements. Habits formed at this time are likely to remain in after years. Here is where the

Academy of Medicine should enter the young practitioner's life. Here he is encouraged to continue his education. This is why the Academy has invited every young practitioner who is a member of a County Society to become a member without payment of dues for five years from the date of his license to practice in the county in which he resides. If he takes advantage of this opportunity to associate with those who are interested in the advancement of scientific medicine, he will not only keep up to date on medical subjects, but will get the habit of taking part in medical discussions which will be of lasting benefit. This is one way in which I believe the Academy of Medicine may assist the young practitioner and play a more important rôle than ever before in his continued education.

Samuel Johnson said, "Knowledge is of two kinds; we know the subject ourselves, or we know where we can find information upon it."

LIBRARY SERVICE OF THE ACADEMY

How many are there who know what a fine library the Academy has to provide information for the medical and dental professions? There is a librarian on duty at certain hours who is always glad to help to find the desired book. If a paper is being prepared, she will gather together all the literature available; and if more is needed she will borrow from other medical libraries. This service is invaluable to the busy doctor who wishes to inform himself on a certain subject. Changes have been made in the library in order to make the more recent publications more easily available. Better reading room facilities have also been arranged. The members should get the habit of using the library more.

Regarding the importance of this continued education there can be no argument for I know of no profession in which it is so essential to keep up to date. From year to year new theories are advanced and new facts proved, and the Academy is the logical organization to disseminate this knowledge. Thus it is of great value to the older practitioner as well as to the beginner.

Thomas Huxley said, "If a little knowledge is dangerous, where is a man who has so much as to be out of danger?"

The physician who considers this seriously will avoid many of the errors which might embarrass any of us. He will learn that besides a knowledge of medical science, he must have a capacity for hard work, and the ability to apply his knowledge in the diagnosis and treatment of disease. He must be an *optimist*. There is no place for a pessimist in the practice of medicine. He must learn to be thorough in his work. How often do we see failures on account of lack of thoroughness in making an examination for a diagnosis, or in carrying out the details of a certain treatment.

In my opinion, too much time is spent in search of new technic, instead of perfecting the simpler methods which have been found to be good. Some physicians change their methods of procedure so frequently that they never become proficient in any. One reason for this is that they take insufficient time to understand the subject, but pick up new ideas without a full understanding of them. Such a doctor is dangerous, for he thinks he is up to date but has not learned to think and decide for himself.

HOME TALENT ON PROGRAMS

We are too likely to have outside speakers for our meetings. There should of course be some of these, but much of the value to be gained in the sectional meetings will be obtained by having every-day subjects discussed by our own members. When a doctor prepares a paper for presentation before a medical group, he always learns something, for the work which he does himself is of more value than what is done for him by others. Discussions of these papers are bound to bring out the facts, and are of value to all taking part.

CLINICAL VS. LABORATORY EVIDENCE

When one has clinical evidence of what he has actually seen in his practice in a number of cases, he has knowledge which no argument can defeat. Clinical study of the patient himself has, I fear, been somewhat neglected. We are apt to rely too much on laboratory reports. Some of these tests are expensive and add greatly to the cost of medical care. The rule carried out in some hospitals which requires routine laboratory tests for all patients is partly

responsible for this indiscriminate use of laboratory tests. Laboratory tests are not always accurate. The technician may err in his findings, and cause a wrong diagnosis to be made. When the laboratory report does not fit the clinical picture, a diagnosis should be reserved until further study of the case can be made. The physician who is trained to study his patient clinically, and to make use of laboratory tests when needed to aid diagnosis, will not only become a successful practitioner but will do much to reduce the cost of illness.

An extreme case came to my attention recently. A physician was unable to make a diagnosis of pregnancy because the x-ray film was not clear. The foetal heart could be heard easily as the patient was six months pregnant.

To quote the late Dr. Franklin Martin, writing of the two Mayos:

"To succeed one must make good. To fulfill the tenets of his calling a doctor must diagnose diseases accurately and cure his patients. To accomplish this he must have knowledge. To possess knowledge of the science of medicine he must familiarize himself with the achievements of the most competent doctors; he must make frequent visits to the masters of surgery and witness their work; he must visit his confreres in other lands; he must know by comparison how nearly right he is, measured by the standards of his peers. When he discovers or achieves something that all medical men should know, he must be unselfish enough to present it at medical meetings and to publish it in medical journals. He must learn to talk; and he must learn to write all of this so that every patient may be benefited by any advance in medical science. His best friends should be his associates in medicine, his scientific books, and the people of all classes who come to him for aid. His recreation should be a change of work; and devotion to his calling should be his greatest pleasure.

"He cannot serve two masters—society and his profession. He must learn to think. He must practice economy. He must practice medicine as a profession and not as a business.

"Rich and poor are afflicted with similar diseases, and he must treat them with equal care and with equal faithfulness. If a doctor makes a mistake, he must endeavor not to make the same mistake twice. If he is criticized, let him make sure that he does not deserved it. If he is misjudged by honest critics, let him endeavor to correct the misunderstanding. If he is the victim of malicious prejudice, let him ignore it. If he is unjustly attacked, let him not stoop to competitive methods. Above all, let him work to develop a judicious mind and a determination to carry out the ideals of his profession for the benefit of every human being with whom he has contact."

LEADERSHIP IN PUBLIC HEALTH

In the present day, a doctor who simply attends the sick is not doing his full share of professional work. He should take an active part in public health work and in medical economics. Social service and welfare groups should not be required to guide the destinies of the medical profession. It is because we have confined ourselves to narrow lines of work, that others have pointed out our broader field. Physicians through their organizations should take the leadership in all public health matters and regain the position they have lost through their lethargy. This, I believe, is now being done in the State of New Jersey; yet, there are many of our members who do very little for the medical welfare of the community.

The field of preventive medicine has grown extensively, and the work performed by physicians and dentists along this line is a credit to their professions. The public as a whole is becoming more and more interested in the prevention of disease, although certain misguided people are actively opposed to some of the procedures necessary to bring about this prevention.

In closing, I wish to express my appreciation for the honor which has come to me in serving as your President. The two years of service have been educational and inspiring, and the contact I have had with the leaders of scientific medicine in New Jersey has given me great pleasure. To be sure, most of the work has been done by my colleagues, by the other officers and by the committees under the leadership of their able chairmen; so that, at the end of my term of office, it seems that I have done very little. To all who have so ably come to my assistance, I extend my sincere thanks. Let me assure you I have tried to carry on the work of my esteemed predecessors and have attempted to make the Academy of Medicine stand out as a worthy place for the continued education of the doctor.

"To look up and not down,
To look forward and not back,
To look out and not in,
To lend a hand."

—Edward Everett Hale.

STATE SOCIETY ACTIVITIES

HOW THE COUNTY MEDICAL SOCIETY BENEFITS ITS MEMBERS

By FRANK OVERTON, M.D., Editor, and LEROY A. WILKES, Executive Officer
The Medical Society of New Jersey

The three learned professions of theology, law and medicine have always been recognized as essential to the well-being of mankind throughout the world. The systems of theology and of law have differed widely in the several countries, and today there are great differences among the nations regarding their churches and their legal systems. But the system of modern medicine is universally accepted throughout the world, and a physician of New Jersey would be at home in a first class hospital in India or China.

THE MEDICAL PROFESSION

The words "The Medical Profession" signify the licensed physicians of a community considered as an aggregation of individuals acting without formal agreements. The term is indefinite and elusive, for in the absence of tangible agreements, no individual physician can speak for the others.

ORGANIZED MEDICINE

The concept of *"The Medical Profession"* is a ghostly abstraction unless it is embodied in the physical form of a *Medical Society,* with officers and a code of standards and procedures. The system of medical societies has made possible the unity of the Medical Profession throughout the world.

THE COUNTY MEDICAL SOCIETY

The fundamental organization of the Medical Profession of the United States is the *County Medical Society.* Two thirds of the practicing physicians of the United States are enrolled in the medical societies of their respective counties; and by virtue of their membership they are also members of their State Societies, and of the national organization,—the American Medical Association. This great system of organized physicians has no rival, and it therefore truly represents the *Medical Profession* of the County, the State, and the Nation.

BENEFITS

The benefits which the people receive from organized medicine are beyond estimation; but this lecture will deal only with those which the members themselves receive, especially those derived from their County and State Societies. These benefits may be classed in four groups:

1. Ethical
2. Fraternal
3. Professional
4. Economic.

1. ETHICAL BENEFITS

The benefits classed as *ethical* are those which flow from the loftiness of the standards of the medical profession in science and civics as well as morals. The word *ethos* was used by the ancient Greek philosophers to indicate a high excellence of the character or nature of a person or an object.

PRIDE OF IDEALS

It is a matter of inward pride with every physician that he has been initiated into the secrets of the medical fraternity whose standards would fall if they were not upheld and promoted by the medical societies. The physician who is not a member of his county medical society is yet indebted to it for the satisfaction of sharing the idealism of the medical profession.

PREVENTION OF DISEASE

Every man is altruistic to some degree. To relieve human pain and sickness is a primal instinct to which every doctor responds, regardless of the personal sacrifice which he imposes upon himself. Yea more,—he seeks to prevent sickness, and thereby he reduces the number of his patrons. The leader in this soul-satisfying work is the *Medical Society,* which seeks to devise the means by which health departments and welfare agencies may share the burden which custom formerly imposed almost entirely on the doctor. For this service every physician is deeply indebted to his Medical Society; and the least he can do to show his appreciation is to join and support his county organization.

COMMUNITY ADVICE

The County Medical Society is the *medical adviser of the community* in all matters pertaining to health and disease, just as the *family doctor* is the adviser to the individual. The community has become *health conscious* because of the rise of the great system of lay health agencies, supported by immense endowments which are used largely for publicity and popular education along health lines. Every doctor has complaints that the agencies ignore or displace him from his natural position as adviser to the community. As a member of the vague entity called the *Medical Profession* the individual physician is well-nigh helpless; but as a member of his County Society he can secure the recognition that is properly his.

The Medical Society of New Jersey has adopted the definite project of recovering this service for the physicians. It seeks to educate the lay health workers regarding the necessity that they consult the Medical Society in all their projects. The means offered to the critical physician for making his protests and proposing the remedies is his *County Medical Society*. The service of his local organization is of incalculable benefit to every physician whether he belongs to it or not.

HOSPITALS

The great system of public hospitals came into existence through organizations of physicians which enlisted the support of lay philanthropists and public officials for the erection and support of the institutions. It is hard to realize that there was scarcely a hospital in existence in this country for a quarter of a century after its independence. It was the organized leadership of physicians that led to the growth of the hospital system during the latter half of the nineteenth century; and today it is their leadership which makes the services of the public hospital available to the people.

The published proceedings of every County Society are replete with discussions of ways and means for extending the services of the local hospitals; and reports of hospital cases constitute a major part of the programs of the Societies. It is an increasing custom that the managers of hospitals require membership in the County Medical Society as one of the qualifications for appointment to their professional staffs. Every physician is indebted to the County Medical Society for the benefit which the hospital is to him in the practice of medicine, for without the organized efforts of the practicing physicians of a community a public hospital is impossible to maintain and conduct.

2. FRATERNAL BENEFITS

No one who is familiar with the attitude of physicians a quarter of a century ago can fail to appreciate the great fraternal benefits of the County Medical Society to the doctor personally. Gone are the days of open jealousy when the physicians of a town would not consult with one another; or when a doctor, called to another's patient, would advise the family "To chuck that medicine out of the window". The development of a high degree of friendliness among physicians is the direct result of their meeting one another in their County Medical Societies. The former antagonisms would soon return if the County Medical Societies were abolished.

FRATERNITY OF THE COUNTY SOCIETY

The County Medical Society is a *fraternity* whose initiates are bound by self-imposed obligations to respect the professional and personal secrets which are reposed in them. Here the doctor may find help in solving the problems which troubled patients have submitted to him in the confessional of the sick room, knowing that his confidences will be fully respected. To bear one another's burdens, to share one another's confidences, to help one another to relieve pain and distress—these are the tenets which the Medical Society exemplifies to a greater degree than any other fraternity. The personal satisfaction of being an active member of the organized Medical Fraternity is one of the major benefits afforded by the County Medical Society.

SOCIAL

The County Medical Society is the doctor's social club. Here the cheerful extrovert finds kindred spirits with whom he indulges in his favorite indoor sport of talk or games; the solemn introvert contemplates the antics of his light-hearted colleagues; and all find relaxation from the mental stress that is inseperable from close association with pain and anxiety. The informal hour and friendly luncheon of the County Medical Society is a welcome balance to the excess of seriousness of a busy day in contact with the sick.

The characteristics of a well balanced physician in his County Society are his *graceful frivolity* during the social hour, and his *subtle simplicity* during the scientific session.

3. PROFESSIONAL BENEFITS

The fundamental object of the County Medical Society is to make its members better practitioners of medicine.

The County Medical Society is the *continuation school* of the practicing physician where he is not only a student, but is also a teacher as he exchanges experiences with his colleagues. It is the most available graduate school in scientific medicine or the treatment of sick individuals, and it stands almost unique in providing clinical courses in the practice of *civic medicine,* or the discharge of those duties which the doctor owes to the community.

SCIENTIFIC MEDICINE

The activity of a physician in his County Medical Society is an index of his proficiency in the *newer forms* of medical practice. A physician who does not apply himself to medical study for five years shows defects of professional knowledge which are evident to his brother practitioners; and in ten years the people notice that he is behind the times.

The two fundamental methods of medical study which are available to every physician are:—

1. Home reading.
2. The school of the County Society.

These two methods are always associated together. The reader of medical literature recites his lessons at the County Society; and those attending the meetings are aroused to study their medical text books and to read their Journals. The educational stimulus of the County Medical Society is one of its greatest and most evident benefits.

ASSOCIATION WITH MEDICAL LEADERS

A peculiarity of the scientific sessions of a County Medical Society is the high class of teaching talent which is available. Eminent specialists welcome the opportunity to give their services to a County Society in order to learn the experience of the family doctors and their point of view. At the same time the members prize the opportunity to meet the leaders with a familiarity which often ripens into close friendship.

CIVIC MEDICINE

The County Medical Society helps the physician to perform the civic duties which he owes to the State in return for his license to engage in private practice. Many forms of skilled assistance are needed in order that the people may utilize the strictly medical services which are delivered by the doctor. These allied services may be listed in three classes as follows:—

1. Hospitals and laboratories—
   Nurses and technicians
2. Health departments—
   Public health nurses
   Dietitians
   Health teachers.
3. Welfare agencies—
   Investigators
   Relief workers
   Lay health organizations.

All these services are accessory to those of medicine, and are properly under medical direction. But many have been developed, supported, and conducted by lay health organizations and "Foundations", and by government officials to such an extent that the non-medical groups often dominate the physicians. These health organizations permeate every community, and deliver their services to every class of persons, including those to whom physicians deliver purely medical services. These overlapping fields often result in misunderstandings regarding the respective fields of service belonging to the medical and the lay groups.

The ultimate delivery of the services of all the lay groups is made by local members and workers who are personally known to family physicians. The County Medical Society therefore occupies a key position in advising the lay workers and outlining the methods of their activities, just as the family doctor directs the service of the bedside nurse. It is both the opportunity and the duty of the members of the County Medical Society to serve on *advisory committees* to the local health organizations, and to take office in their boards, and to define the respective fields of the lay and the medical workers.

It is equally the duty of a doctor whose advice is asked by a lay organization to refer the request to the County Medical Society. When the practicing physicians realize their duty to perform these civic duties through their County Medical Societies, harmony of action of the medical and lay health groups will be attained. The active participation of the members of County Societies in the practice of civic medicine is urgently needed for their own self-protection lest they be reduced to the status of servants of the State.

TEMPERAMENTS AND ABILITIES

The work of County Medical Societies is done by committees whose members are chosen because of their temperaments and abilities. If a physician is interested in politics, his place is on the legislative committee; if he is socially inclined, he belongs on the public re-

lations committee where he associates with leaders of the parent-teachers' associations, and women's clubs.

A high reputation for skill in scientific medicine is not necessary in order that a physician may give excellent service in civic medicine; but it is extremely desirable that he be intimate with the leaders of the particular lay group whom the Society seeks to influence. The County Medical Society offers to every member a position of honor on an active committee and the opportunity to do satisfying service.

4. ECONOMIC BENEFITS

The most evident service rendered by the County Medical Society is that of securing *adequate pay* to the doctor for his services to the sick.

From time immemorial the doctors' patients have been divided into three classes according to the degree of their payment for his services:—

1. Pay in full
2. Pay in part
3. Pay little or nothing.

The costs of medical service have been borne by three parties:—

1. The doctor
2. The patient
3. The public.

Up to recent years the only part of medical expense which the public bore was that for a meager service to friendless *paupers*. By far the greater part of the burden of serving those with low incomes was borne by the individual doctor. If he was fortunately situated, he collected enough from his prosperous patients to enable him to donate his services to his poorer patients. The entrance of the *public* between the doctor and his patient became necessary when the business depression reduced the number of pay patients and increased non-paying class to abnormal proportions. But before the depression began the economics of the delivery of medical services were unsatisfactory as were revealed by the nation-wide study made by the Committee on the Costs of Medical Care during the prosperous years ending in 1929. In those years the amount annually received by the doctors of the United States was about one billion dollars. This amount divided among the 125,000 physicians in active practice gave each doctor a gross income of $7500, which would enable him to bear the burden of the free care of the poor. But the income was distributed extremely unevenly, and the greater number of doctors received less than $3000 gross annual income.

The Committee also reported that the services which physicians were delivering to about half of their patients were inadequate because of their low economic condition; and it prescribed the remedy of the man in modern business who would have the government *buy* the medical service from the doctor, and *sell* it to the patients of low incomes on the installment plan called *medical insurance*.

The favorable reception of the insurance plan by the Federal Government aroused the leaders of the medical societies to devise plans by which physicians themselves should control the economics of their practice. The Bulletin of the American Medical Association of June 1935, listed over 175 plans of economic systems to be operated by physicians. The plan that was adopted by the Medical Society of the District of Columbia was outstanding in its simplicity, its efficiency, and its adaptability to any community. The system has been adopted by the Medical Societies of Essex and Passaic Counties, New Jersey, and its features were described in The Journal of The Medical Society of New Jersey of October, 1935.

THE WASHINGTON PLAN

The Washington Plan is based on the principle that the great economic need of physicians is a system for making collections from those who are able to pay the doctor something for his services. It includes dentists as well as physicians.

The plan recognizes the three economic groups of patients:—

Those able to pay their medical bills *in full* are not affected by the plan.

The *indigent* patients continue under the care of Welfare Departments, as at present.

A person able to pay his medical bill *in part* agrees with his physician as to the amount which he can pay monthly over a period not longer than one year. The collections are made by a corporation,—the Medical-Dental Service Bureau—formed and controlled by physicians and dentists. Ten per cent of the collections are retained by the Bureau, and this amount is sufficient to cover the expenses of its operation.

The Bureau utilizes the services of the welfare agencies of the City of Washington for investigating the economic condition of the patients, and for assigning the needy to existing agencies for relief. The system harmonizes the activities of all the health and relief agencies in the delivery of medical and dental services.

The Texas State Journal of Medicine of October 1935, page 412, describes a modification of the Washington plan, adapted to smaller communities, which has been devised by the Medical Society of Bexar County, Texas, in which the city of San Antonio is situated. The system involves the following modifications of the Washington plan:—

1. A committee of the county societies, or of the local societies, shall administer the system.
2. The doctor shall form his own judgment of the economic status of his patient, and shall agree with him regarding the size of his bill, and the monthly installments to be paid.
3. A local bank shall be the collecting agent.

The Washington plan or its modification offers the means by which the members of the County Medical Society may solve their own local problem of the economic relation of the individual physician to his patient.

ACTIVE PARTICIPATION ESSENTIAL

One sometimes hears a physician complain that the County Medical Society does not do enough *for him;*—then why should he support it?

The Medical Society can do little for the physician who will not help himself. The Society is not designated to be a dispenser of *free services* to its members; but it is a source of inspiration and assistance to those who will use them. The member who invests his abilities in the *active support* of his County Society will receive a dividend of one hundred per cent on his investment of time and energy.

A member who is actively supporting his County Medical Society still needs a constant supply of information and inspiration, which he will get from two principal sources:

1. The Executive Office.
2. The Journal.

The Executive Office is the *service station* for every form of activity that is carried on by the State Society or its twenty-one component societies. The *Executive Officer* is ready to assist any County Society either by letter, by telephone, or by personal visitation. The constant expansion of his field of service is conclusive evidence of increasing activity and progressive originality on part of the members of the County Societies.

The *Journal,* which comes to every member once a month, gives a summary of the information which is constantly flowing through the Executive Office, regarding current activities of the State and County Societies. Its value to every member is that of an encyclopedia which he will preserve on his library shelf and will consult under every condition of the practice of civic medicine.

LICENSING OSTEOPATHS TO PRACTICE MEDICINE AND SURGERY

In accordance with an agreement between the officers of The Medical Society of New Jersey and those of the Osteopathic Society, made in the early part of the year 1935, the two organizations joined in supporting an amendment to the Medical Practice Act defining the conditions under which osteopaths would be given the right to practice medicine and surgery. This Bill was passed by the Legislature and was approved by the Governor on May 23, 1935.

In accordance with the provisions of Section 4, paragraphs C and F of the amended law, the Board of Medical Examiners adopted rules and regulations defining the conditions which were referred to the judgment of the Board. At the request of Dr. Arthur W. Belting, Secretary of the Board, these rules and regulations are printed in the following article.

DEFINITION OF OSTEOPATHY

The amended law, Chapter 226, Laws of 1935, Section 4 D, defines the practice of osteopathy as follows:

"Within the meaning of the provisions of this section the practice of osteopathy shall include the diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity, physical or mental condition; provided, however, that a license to practice osteopathy shall not permit the holder thereof to prescribe or administer drugs for internal use in th etreatment of any human disease, pain, injury, deformity, physical or mental condition or to perform such surgical operations as require cutting."

DEFINITION OF THE PRACTICE OF MEDICINE

The practice of medicine is defined in the Medical Practice Act, Section 35, as follows:

"Any person shall be regarded as practicing medicine and surgery, within the meaning of this Act who shall use the words or letters 'Dr.', 'Doctor', 'Professor', 'M.D.', or 'M.B.', in connection with his or her name, or any other title intending to imply or designate him or her as a practitioner of medicine or surgery in any of its branches, and who in connection with such title or titles or without the use of such titles, or any of them, holds himself or herself out as being able to diagnose, treat, operate

or prescribe for any human disease, pain, injury, deformity or physical condition, or who shall either offer or undertake by any means or methods to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition; and it is further provided, that the provisions of this Act shall apply to all persons professing and attempting to cure diseases by means of the so-called systems of 'faith-curism', 'mind-healing', 'laying-on-of-hands' and other similar systems."

The amended law provides the means by which a graduate of an approved osteopathic school or college may be licensed to practice medicine and surgery, the conditions being that he shall conform to the standards of those practicing medicine and surgery; and that the osteopathic schools and hospitals shall be of a scientific grade equal to those of regular physicians.

The rules and regulations adopted by the Board of Medical Examiners are as follows:

1. Requirements for Those Holding Osteopathic Licenses to Practice in This State Who Desire to Practice Medicine and Surgery, and Who Offer Evidence of Having Had at Least Three Years of Practice in Surgery in an Approved Hospital, and Who Have Fulfilled All Other Requirements of Chapter 226, P. L. 1935

Requirements for any person duly licensed and registered to practice osteopathy in the State of New Jersey and who presents satisfactory proof that he or she has had at least three years of practice of surgery in a hospital approved by the State Board of Medical Examiners of New Jersey, to be admitted to examination and to be licensed to practice medicine and surgery in the State of New Jersey, under Section F of an Act to amend an act entitled "An Act to regulate the practice of medicine and surgery, to license physicians and surgeons, and to punish persons violating the provisions thereof", approved May twenty-second, one thousand eight hundred and ninety-four, and amendments thereof and supplements thereto, said amendment containing Section F, having been enacted May 23, 1935:

To be admitted to examination:

1. The applicant shall be duly registered and licensed to practice osteopathy in the State of New Jersey.
2. The applicant shall submit proof satisfactory to the State Board that he or she,
   a. has had at least three years' practice of surgery in
   b. a hospital approved by the State Board.
3. The applicant shall submit as evidence of his or her qualifications to practice medicine or surgery,
   a. Fifty case records in complete detail of major operations performed by him and in which he was the responsible surgeon,
   b. and a brief abstract of at least fifty other major operations performed by him.

To be licensed to practice Medicine and Surgery in the State of New Jersey: After compliance with the requirements for admission to examination, the applicant shall have passed with a grade of 75 per cent in each of the examinations of materia medica, therapeutics, and surgery, which examinations shall have been the same as those given to the medical candidates and shall have been taken at the same time and place.

Three years' practice of surgery shall be held to mean that the applicant has devoted at least 50 per cent of his professional activity over a period of three years to the practice of surgery.

An approved hospital shall be held to be one approved by the State Board of Medical Examiners of New Jersey. The State Board may, in determining its approval, accept any or all of the following:

1. Approval by the American Medical Association.
2. Approval by the American College of Surgeons.
3. Approval by the Bureau of Hospitals of the American Osteopathic Association.
4. Approval by the Associated Hospitals of Osteopathy.
5. Approval by the American College of Osteopathic Surgeons.
6. Approval by the New Jersey Osteopathic Society.

2. Requirements for Those Now Holding Osteopathic Licenses to Practice in This State Who Desire to Practice Medicine and Surgery, and Who Offer Evidence of Having Completed an Approved Post-Graduate Course of Two Years in an Approved School of Medicine or Osteopathy, and Who Have Fulfilled All Other Requirements of Laws of 1935, Chapter 226, State of New Jersey

1. The post-graduate course shall have been approved in advance of each year or semester by the State Board of Medical Examiners.

2. The school of osteopathy or medicine shall have been approved by the State Board of Medical Examiners before approval is given on the post-graduate course.

3. The course of two years must be of two successive years; except, however, that the Board may in its discretion approve a lapse of not more than two years between the post-graduate years, provided the cause of the lapse of time has been one not under the control of the applicant for license.

4. The course shall consist of instruction in medicine, surgery, pediatrics, obstetrics and gynecology, pathology, pharmacology, radiology, and certain elective subjects, in approximately the same proportion of hours as is set forth in the curriculum for an approved college of medicine or osteopathy.

5. Each post-graduate year shall consist of approximately 1000 hours.

6. Attendance must be personal and such as is required of undergraduate students.

7. All courses must have been successfully passed and completed. No uncompleted course or semester shall be accepted.

3. Definition of an Approved Professional or Medical, or Osteopathic College

Section 4, Paragraph C, of the Medical Practice Act, as amended by Chapter 226, P. L. 1935, in part provides:

"C. Every applicant for admission to examination for a license to practice medicine or surgery, shall, in addition to the above requirements, prove to said board that he has received a diploma conferring the degree of doctor of medicine or degree of doctor of osteopathy from some legally incorporated medical or professional college of the United States, which college, in the opinion of said board, was in good standing at the time of the issuance of said diploma or license conferring the full right to practice all of the branches of medicine and surgery in some foreign country, and further prove that prior to the receipt of such diploma from any such medical or professional college of the United States, or such diploma or license conferring the right to practice medicine and surgery, as aforesaid, he had studied medicine, in all its branches, not less than four full school years, including four satisfactory courses of lectures of at least seven months each, in four different calendar years in some legally incorporated and registered American or foreign medical or professional college or colleges in good standing in the opinion of said board; such applicant, if he has graduated after the first day of July, one thousand nine hundred and sixteen, shall in addition to the above requirements, further prove to said board that after receiving such degree, diploma or license, he has served as an interne for at least one year in a hospital approved by said board;"

Section 4, Paragraph G, provides:

"G. For the purpose of this section a professional college shall be taken to mean a medical college or osteopathic college; provided, however, that in all instances, such college shall be approved by the State Board of Medical Examiners."

For the purpose of these provisions of the Medical Practice Act, a medical or osteopathic college, to be in good standing in the opinion of the Board, shall be one that teaches the following curriculum and meets all other requirements of the Board:

Curriculum

The entire course of four years shall consist of from 3600 to 4400 hours, distributed as from 900 to 1100 hours per year, and shall be grouped as set forth in the following schedule, each group to be allotted approximately the percentage of hours of the whole number of hours in the courses as stated:

1.	Anatomy, including embryology and Histology	14	—	18½%
2.	Physiology	4½	—	6 %
3.	Biochemistry	3½	—	4½%
4.	Pathology, Bacteriology and Immunology	10	—	13 %
5.	Pharmacology	4	—	5 %
6.	Hygiene and Sanitation	3	—	4 %
7.	General Medicine	20	—	26½%
	Neurology and Psychiatry			
	Pediatrics			
	Dermatology and Syphilis			
8.	General Surgery	13	—	17½%
	Orthopedic Surgery			
	Urology			
	Ophthalmology			
	Otolaryngology			
	Roentgenology			
9.	Obstetrics and Gynecology	4	—	5 %
	Total	76	—	100 %
	Electives	24	—	0 %

Rating

The approval of a college maintaining the required curriculum shall be based upon personal inspection whenever possible, and in all other cases the Board may in its discretion accept the rating of the Association of American Medical Colleges, The American Institute of Homeopathy, The National Eclectic Medical Association or the American Association of Osteopathic Colleges; provided that this ruling shall not effect applicants who matriculated in an approved medical school or college prior to May 21st, 1931; and provided, further, that the Board's ruling of September 20th, 1933, be followed in the case of foreign medical schools and colleges.

4. Essentials for Approval of Internship of Two Years Required of Applicants for License to Practice Medicine and Surgery under Section F of Laws of New Jersey, 1935, Chapter 226

In all respects the requirements for this two year's internship shall be the same as those required for the one year's internship in Section C, except, however, that the time shall be two years, and further, that the two years shall be continuous, except, however, that the Board may in its discretion approve a lapse of not more than two years between the post-graduate courses, provided that the cause of the lapse of time has been one not under the control of the applicant for license.

5. Essentials for Approval of the Hospital Intern Year, as Set Forth as a Requirement After Graduation from a Medical or Osteopathic College in Section C of Chapter 226, Laws of 1935, State of New Jersey; and Essentials Required in a Hospital Approved for Intern Training (Revised October 9, 1935)

I. GENERAL STATEMENTS

1. *Welfare of the Patients.*—Only hospitals in which the entire plant and personnel constantly function primarily in the interest of the patient are acceptable for accrediting as institutions for the training of interns, however abundant the equipment of the hospital may be.

2. *Minimum Number of Beds and Patients.*—The hospital shall have at least 75 beds and a daily average of 50 or more patient, available for intern instruction.

3. *Only General Hospitals Eligible.*—The hospital shall provide a variety of medical, surgical, obstetric and children patients in reasonable proportion, so as to offer interns and graduate students that clinical training which every medical practitioner should have. A hospital that is lacking in types of patients, such as maternity cases or children, may, by an approved working affiliation with other nearby institutions, supply the additional clinical material necessary.

4. *Interns' Living Quarters.*—The hospital shall provide reasonably comfortable living quarters for the interns with opportunities for recreation, both indoor and outdoor, appropriate to the locality and environment of the hospital.

II. THE STAFF OF THE HOSPITAL

1. *Character of Staff.*—There must be an organized staff of ethical physicians who are of unquestioned professional and moral integrity; who are proficient in general practice or in the special fields to which they devote themselves; who give personal attention to the patients under their charge, and who will provide adequate facilities, instruction and that sympathetic coöperation without which interns and graduate students cannot obtain the practical training for which they are serving the hospital.

2. *Staff Conferences and Meetings.*—It is expected that there shall be, at least fortnightly, clinical-pathologic conferences or other regular staff meetings at which histories and clinical findings in selected patients may be reviewed and particularly where, in the death of patients, special study, including necropsy findings when possible, shall be undertaken. The interns and graduate students should be requested to attend these meetings and to take part in the discussions and procedures.

III. THE EQUIPMENT OF THE HOSPITAL

1. *Laboratory.*—There must be a clinical laboratory in charge of a pathologist of attainments and standing at least equal to those of other staff members, who shall be in charge of the laboratory, supervise the work of, and give instructions to the interns. The laboratory work of the interns shall include not only the simple clinical tests, but also the more technical chemical, bacteriologic and serologic work and examinations. At least one full-time technician shall be employed.

2. *Roentgen Ray.*—The roentgen-ray de-

partment shall be in charge of a roentgenologist whose attainments are at least equal to those of other staff members and who shall supervise and instruct the interns in all essential phases of roentgenology. The department must be equipped to do roentgenographic, fluoroscopic, and therapeutic work. The intern should receive instruction both in regard to technic and dangers of roentgen-ray application and also in plate reading and in the therapeutic uses of the roentgen ray.

3. *Anesthesia.*—The hospital is expected to provide equipment and facilities for, and expert supervision, preferably by a staff member, over the administering of the usual kinds of local and general anesthetics and the instruction of interns in anesthesiology.

IV. HISTORIES AND RECORDS

1. *Complete Histories.*—There must be complete histories, giving the patient's complaint, physical examination at time of admission to hospital, preliminary diagnosis, laboratory findings, description of operation, if any, daily record of case, final diagnosis, condition and date when discharged from hospital, end-results, and in case of death, necropsy findings, if necropsy is performed.

2. *Endorsement of Histories.*—The histories should show, by signatures or initials, all persons writing them or parts of them, as well as the staff members by whom the histories are verified. Likewise all orders and progress notes should be initialed or signed.

3. *Records.*—The records should be in charge of some competent person, preferably a trained office secretary; they should be kept complete and should include an alphabetical index of the patients, and another arranged by diagnosis, and the record should be so filed as to be easily accessible from either index.

V. THE WORK OF THE INTERN

1. *Supervised Responsibility.*—The intern should assume, under careful supervision, an increasing responsibility in the diagnosis of diseases, daily observation, care and treatment of the patients under his service.

2. *Type of Intern Service.*—In the rotation of service there should be a smoothly working plan by which interns proceed in a certain routine through the various services. There should not be more than four or five changes in any single year's service; more than this cause unnecessary confusion.

3. *Scope of Intern Instruction.*—The hospital, through designated members of its staff, should provide adequate instruction and experience for the interns who, in effect, are fifth year medical students, in medicine, pediatrics, surgery, obstetrics and laboratory work throughout their terms of service. This instruction shall include three months in medicine and its branches, three months in surgery and its branches, and the balance of one year period of internship shall be substantially equally divided between the other departments of the hospital to include a reasonable amount of time in the various out-patient departments.

4. *Length of Intern Service.*—The intern service shall cover at least twelve consecutive months, but may to great advantage be extened through a longer period.

5. *Assignment of Work.*—The number of patients assigned to each intern and the routine work required of him should not demand more than eight (at most, ten) hours daily. He should have ample time not only to study and read up about his patients, but also to permit of a reasonable amount of recreation.

6. *Clinical Laboratory Work.*—The intern should himself perform the laboratory work, or at least have the full benefit of laboratory findings, for each patient under his charge. A reasonable amount of work in the various laboratory tests—urine, blood, gastric contents, stools—should be performed by the intern to give him the desired amount of laboratory experience, but he should not have to undergo an unreasonable amount of routine work. Laboratory experience in the more technical, chemical, bacteriologic and serologic work may well be obtained in assisting the expert pathologist.

7. *Necropsies.*—The intern, as far as possible, should obtain experience in making necropsies under the direction of the pathologist. The hospital should also obtain as high a percentage of necropsies as is possible. This percentage is usually looked on as an index of the pathologic teaching carried on as of the general professional standard in the hospital.

8. *Anesthesia.*—The intern shall obtain instruction and experience in the various kinds of anesthetics, under experienced medical supervision unless he is known to have had adequate instruction in his undergraduate medical course.

9. *Obstetrics.*—The intern shall have experience, under the supervision of designated members of the staff, in the delivery of normal maternity patients and also in assisting in all abnormal cases.

10. *Roentgen Ray.*—The intern shall receive from the roentgenologist or other qualified member of the hospital staff a reasonable amount of instruction in the technic and the therapeutics of the roentgen ray, as well as in

the interpretation of plates and fluroscopic findings.

11. *Dietetics.*—The intern shall receive some instruction by a qualified staff member, in the feeding of both infants and adults, as required in various diseases or conditions, and a reasonable amount of technical experience under a trained dietitian is desirable.

12. *Rules Regarding Interns.*—The hospital shall have a set of printed or written rules and regulations defining the rights, duties, and privileges of the interns, a copy of which should be furnished to each intern.

13. *Purpose of Internship.*—It is emphasized that the object of the general internship is to round out the medical graduate's training, so as to enable him to enter on the general practice of medicine, and not to equip him to enter directly on any specialty. For the latter, he should obtain further and different instruction.

14. *Faithful Service from Intern Expected.*—For all the privileges granted the intern, it is understood, of course, that the hospital has the right to expect faithful service in return.

VI. ADMISSION TO THE APPROVED LIST

1. *Application for Approval.*—Hospitals that want to be accredited for intern training should apply to the State Board of Medical Examiners of New Jersey, Trenton, New Jersey.

2. *Survey Report.*—A hospital Survey Report Blank in duplicate will be supplied on application. This should be filled out carefully by the superintendent or by some staff member who is acquainted with the intern service in the hospital. In addition, the Board desires also: (a) An outline of the course, or order, in which the intern progresses through the different departments; and (b) the name of responsible instructor, length of time and amount of work required of the intern in each department.

TRUSTEES' MEETING

A meeting of the Board of Trustees of The Medical Society of New Jersey was held in the Executive Offices in Trenton on the afternoon of Sunday, November 3, 1935. Dr. Frederic J. Quigley, Chairman of the Board, presided, and Dr. LeRoy A. Wilkes, Executive Officer, acted as secretary in the absence of Dr. Nafey, who was in California.

Those present were: Drs. Quigley, Haussling, Green, Eagleton, North, Davis, Snedecor, Lewis, Morrison, Conaway and Cole. The A. M. A. Delegates and Alternates present were: Drs. Mulford, English, Read and Weigel. Dr. Stanley H. Nichols, Chairman of the State Public Health Committee, was also present.

Chairman Quigley announced that the first topic of the day was an outgrowth of the conference of the Medical Economics Committee's participating in the *Eastern Inter-State Medical Economics Conference* held at the Hotel Lexington, New York City, October 13th, 1935. (Journal of November 1935, page 660.)

Before this Inter-state Conference met, a special committee of The Medical Society of New Jersey had been appointed by the Trustees to formulate specific recommendations regarding medical economics to be submitted to the conference. This committee consisted of Drs. Quigley, Herrman, Snedecor, Haggerty and Read; and also the members of the Subcommittee on Medical Practice of the Welfare Committee, consisting of Drs. Lewis, Wood, Wilson and Ulmer. This combined committee adopted a set of recommendations which had been proposed by Dr. Lewis and which were printed in the November Journal, page 661.

The essential feature of the report of Dr. Lewis was the suggestion that the Trustees of the A. M. A. be requested to call a meeting of the House of Delegates of the A. M. A. in the near future for the purpose of considering the acute medical economics problems of the medical profession. The report was presented before the Inter-state Conference, which, after serious consideration, unanimously adopted the recommendations of Dr. Lewis and approved the petition that a special meeting of the House of Delegates of the A. M. A. should be called.

On November 3, 1935, the Board of Trustees of The Medical Society of New Jersey considered the action of the Inter-state Economics Conference, and voted to petition the Trustees of the A. M. A. to consider the recommendations that had been approved by the Eastern Interstate Medical Economics Conference, and especially the suggestion that a special meeting of the House of Delegates of the A. M. A. be called in January or February to consider only questions of medical economics.

In accordance with the action of the Board of Trustees, Dr. Marcus W. Newcomb, President of The Medical Society of New Jersey,

sent the following letter to the officials of the A. M. A. on November 14, 1935:

November 14, 1935.

Dr. James S. McLester, President
American Medical Association
Birmingham, Alabama
and
Dr. Rock Sleyster, Chairman
Board of Trustees
American Medical Association
Wauwatosa, Wisconsin

My Dear Doctors:

At the recent meeting, October 13th, of the Eastern Interstate Conference on Medical Economics, held in New York City, thirty-five members from seven component societies of the American Medical Association participated: New York, Pennsylvania, Maryland, Indiana, Michigan, District of Columbia and New Jersey.

Preliminary to this meeting, the Board of Trustees of The Medical Society of New Jersey appointed a special committee for the specific purpose of formulating a broad general program of Medical Economics to be submitted to the Conference, a copy of which is attached hereto.

The proposals of The Medical Society of New Jersey met with the spontaneous and unanimous approval of the members of the Conference. The Conference also approved the suggestion—and this suggestion was not initiated by the representatives of New Jersey—that the Board of Trustees of The Medical Society of New Jersey memorialize the Board of Trustees of the American Medical Association to take action in harmony with the proposals made by The Medical Society of New Jersey and adopted by the Conference.

As a direct outcome of the action taken by the Eastern Interstate Conference on Medical Economics at the meeting on October 13th, a special meeting of the Board of Trustees of The Medical Society of New Jersey was held on November 3rd, and resulted in the adoption, unanimously, of the following resolution which I have been requested to officially transmit to your honorable Board:

"Whereas, the Board of Trustees of The Medical Society of New Jersey has 'authority to act for the Society between Annual Meetings', therefore be it

"Resolved, That the Board of Trustees of the American Medical Association be and hereby is respectfully but earnestly petitioned to consider the attached proposals and, particularly, the suggestion made that a special meeting of the House of Delegates be called by your honorable Board to meet in January or February; this meeting to be devoted solely to Medical Economics."

With assurance of my high esteem, I am.

Sincerely yours,

MARCUS W. NEWCOMB, M.D.,
President.

Copies of this letter were also sent to each member of the Board of Trustees of the A. M. A., the President-elect of the A. M. A., the Secretary of the A. M. A., each President and Secretary of the State and Territorial Medical Societies, and to each member of the Eastern Interstate Medical Economics Conference.

Dr. Eagleton moved, Dr. Conaway seconded the motion, that the action of the Board of Trustees of The Medical Society of New Jersey, in regard to the petition for a special meeting of the House of Delegates of the A. M. A., be published in our next Journal of the Society. Carried.

FREDERIC J. QUIGLEY,
Chairman.

LEROY A. WILKES,
Acting Secretary.

CONFERENCE OF STATE SECRETARIES AND EDITORS

The annual conference of the Secretaries and Editors of the State Medical Societies conducted by the American Medical Association, at its own expense, met in the Palmer House, Chicago, on Friday and Saturday, November 15 and 16, 1935, with eighty-five members present. The meeting was opened at 10 a. m. by Dr. Rock Sleyster, Chairman of the Board of Trustees of the A. M. A. Dr. E. A. Meyerding, Secretary of the Minnesota State Medical Association, was chosen to preside over the conference.

Those attending the conference from New Jersey were Dr. J. B. Morrison, Secretary; Dr. LeRoy A. Wilkes, Executive Officer, and Dr. Frank Overton, Editor.

The official program, which had been prepared by Dr. Olin West, Secretary of the A. M. A., was carried out, as follows:

Address. James S. McLester, President of the American Medical Association.

Reciprocal Relations Between State and County Societies and the Council on Medical Education and Hospitals. W. D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Some Phases of the Work of the Council on Pharmacy and Chemistry. Paul Nicholas Leech, Secretary of the Council on Pharmacy and Chemistry of the American Medical Association.

Our Potential Post-graduate Resources and the Training of Teachers. Ralph H. Pino, Detroit.

Address. J. Tate Mason, President-elect of the American Medical Association.

The Need for Concerted Action on the Part of All Units of the Organized Profession. D. F. Harbridge, Secretary of the Arizona State Medical Association.

A Basis for Future Developments of Medical Service. J. G. Crownhart, Secretary of the State Medical Society of Wisconsin.

The American Medical Association and State Medical Journals. E. M. Shanklin, Editor of the Journal of the Indiana State Medical Association.

Publicity of Information Regarding Medical Economics. W. F. Braasch, Rochester, Minn.

A Survey of Medical Organizations. Morris Fishbein, Editor of The Journal of the American Medical Association.

Open Discussions:

Topics Submitted by the Committee on Legislative Activities.

The Social Security Act.

Health Surveys.

Dual Membership.

Helping the Patient to Secure Competent Medical Service.

The addresses will be published in the Monthly Bulletin of the A. M. A., if the precedents of former conferences are followed.

Dr. McLester gave a twenty-minute talk on Medicine in Soviet Russia as he found it during his attendance at the Physiology Conference in Moscow last summer. His description of the unsatisfactory conditions coincided with those of other observers.

Dr. Cutter described the system by which the A. M. A. inspects medical schools and hospitals. The reports of the committee are contained in the Journal of the A. M. A., the last two being that on hospitals approved for interneships and service in the specialties, in the issue of August 31, 1935, and that listing pathologists, in the Journal of October 26, 1935.

These reports are valuable sources of information to hospitals, medical societies, and practitioners seeking reliable information for the benefit of their patients.

Dr. Leech described the work of the Council on Pharmacy and Chemistry of the A. M. A. in analyzing pharmaceutical preparations and discussed complaints which had been received from those who were dissatisfied with the action of the Council. He specifically mentioned Mr. Ambruster of New Jersey, and referred to Dr. Rusby, of Newark.

In the discussion, Dr. Fishbein, Editor of the Journal of the A. M. A., continued the criticism of the Ambruster controversy now seven years old, and said that the fact that it persists shows first, the influence of money, and second, that opponents of the A. M. A. are behind the controversy, mentioning "throwaway" journals. He closed by saying that the Council on Pharmacy and Chemistry was the least vulnerable of all the divisions of the A. M. A.

Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, replied that the New Jersey Society is a virile organization and has made an impartial investigation of the Pure Food and Drug situation, and also had made proper requests through its own A. M. A. Delegates in two separate years for information regarding the enforcement of the Pure Food and Drug Act before endeavoring to obtain information through the aid of other State Medical Society officers.

Dr. Leech's paper with its discussion by A. M. A. representatives was the only discordant note in the meeting. The New Jersey representatives were personally treated with courteous consideration.

Mr. Crownhart gave a formal paper describing some of the activities of the Minnesota State Medical Association. In the discussion, Dr. C. B. Conklin, Secretary of the Medical Society of the District of Columbia, said that he regretted that its plan of the Medical-Dental Service Bureau was called the *Washington Plan*, and that he was anxious that the A. M. A. would adopt a definite plan and relieve his Society of the burden of answering numerous inquiries regarding the operation of his city's project.

Dr. C. T. Ekelund, Secretary of the Michigan State Medical Society, and Dr. F. C. Warnshuis, Secretary of the California Medical Association, described the economic plans proposed in their States.

The entire discussion of Mr. Crownhart's paper was dignified and informative.

The address of Dr. Pino was a formal presentation of the educational projects of the Wayne County (Detroit) Medical Society, especially those in developing young men as specialists, each in the same restricted branch of medical service, such as varicose veins.

Dr. Warnshuis, of California; Dr. McBrayer, of North Carolina; Dr. Irving, of New York, and Dr. Wilkes, of New Jersey, discussed some points of the post-graduate instruction in their respective States. In all, an hour was devoted to the main paper and its discussion.

The address of Dr. J. Tate Mason, President-elect of the A. M. A., was a defense of the policies of the national organization, stating that the more remote the State Societies were from the headquarters of the A. M. A. in Chicago, the greater the degree of their complaints. He made the very practical suggestion that each State should work out its

own local problems. Dr. Mason also suggested that each State Medical Society should send a representative to the headquarters of the A. M. A. and spend several days there to see how its varied activities are conducted.

Dr. Shanklin, Editor of the Indiana Journal, in his address, defended the policies of the A. M. A., but said that what was urgently needed was some means of bridging the gap in organization and understanding between the A. M. A. and the State Societies. This was the feeling of the representatives from New Jersey, although there seemed to be no opportunity of speaking on that point; however, the New Jersey representatives emphasized it in private conversations with some of the A. M. A. leaders, and met with a courteous reception. (See editorial, page 684.)

The address of Dr. W. F. Braasch was a valuable contribution to the conference, although the lateness of the hour prevented its satisfactory discussion. The address will be available in the A. M. A. Bulletin.

Dr. Fishbein, in his historical survey of medical organization, bombarded the audience with an interesting array of facts given too rapidly for their proper digestion and assimilation. His printed address in the Bulletin will be both interesting and informative.

To the delegates, the noon luncheon and the evening supper will be remembered with pleasure and profit for the opportunities to meet their colleagues and discuss their common problems intimately. These social features were carried out with greater efficiency than at any previous conference, and are great incentives for representatives to attend the meetings.

The evening dinner was announced to be for the benefit of the Editors, but as a matter of fact the Secretaries came and were cordially received and entered heartily into the discussions. Dr. Holman Taylor, Secretary-Editor of the State Medical Association of Texas, presided, and with humor and tact directed the animated discussions along lines that were orderly and practical. Among the topics discussed were:

1. Copyrighting the Journals.
2. Liquor advertisements.
3. Commissions paid to the Coöperative Medical Advertising Bureau.
4. Free Journals on the exchange list.
5. Post office regulations regarding mailing the Journals.
6. Exchanging with County Society Bulletins.
7. Sending Journals to members in arrears of dues.
8. Use of A. M. A. material.
9. Fillers in the advertising pages.
10. Mention of non-approved drugs in articles in the scientific department.
11. Editorials on joining the A. M. A. as fellows.
12. Getting A. M. A. data on prospective members of County Societies.
13. Order of paging the several departments in the Journals.
14. Uniform place of the index in the Journals.
15. Supervision of articles and editorials by the Publication Committee.
16. The Editors' independence in accepting articles.

The evening's informal discussion was the most valuable feature of the conference, especially to the Editors of the Journals. It is hoped that this feature will be repeated in future conferences.

It was the consensus of opinion that the conference was the most practical and useful one that has been held, and that it will be an incentive for every State Secretary and Editor to attend those to be held in the future.

VISIT OF A. M. A. PRESIDENT-ELECT

The members of The Medical Society of New Jersey will be gratified to hear that Dr. J. Tate Mason, of Seattle, Washington, President-elect of the American Medical Association, came to Newark on the morning of Friday, November 29, 1935, in order to meet the Trustees of The Medical Society of New Jersey and the A. M. A. Delegates and talk over problems of current interest to the State and the National bodies, in an informal fraternal meeting. The importance of the Conference is to be judged in the light of the report of the Conference of State Secretaries and Editors (preceding article), and of the editorial on page 684. The meeting was entirely constructive and friendly, and will doubtless lead to a fuller understanding and coöperation between the American Medical Association and The Medical Society of New Jersey.

THE DOCTOR IN THE WORKS PROGRESS ADMINISTRATION

By Spencer T. Snedecor, M.D.

The Civil Works Administration (C. W. A.) has been succeeded by two similar organizations,—the Public Works Administration (P. W. A.) and the Works Progress Administration (W. P. A.). Since they are known by the same letters, but in a different order, physicians are likely to confuse the two projects.

The P. W. A. has charge of projects in which the major cost is for material, as in bridge building. The cost of a project per person employed is around $5000.

The major cost of a W. P. A. project is that for personal service, which is about $900 for each person employed. A typical W. P. A. project is that of making surveys of social conditions and promoting public health projects, such as the Public Health Hour of The Medical Society of New Jersey. The State Administrator of the W. P. A. in New Jersey is the Honorable William H. J. Ely, 1060 Broad Street, Newark, N. J.

The W. P. A. does not make provision for the treatment of sickness of its employees, for its theory is that the wages paid are sufficient to enable the recipient to pay for the medical services to himself and his family,—but with this statement the medical profession does not agree. However, the W. P. A. makes provision for medical services to its emeployees who are injured in accidents occurring in the line of duty. This payment is similar to that of workmen's compensation.

A visit to Washington headquarters of the United States Employees' Compensation Commission on November 16, 1935, cleared up a great deal of confusion which had existed in our minds about the present working of the compensation rules. We find that both medical and hospital bills for injured W. P. A. workers will be paid for, and on a better basis than during the time of existence of the Civil Works Administration.

Dr. Paul D. Stewart, who has become medical director of the Commission since that last government work project assured physicians of his desire to be fair to them and to coöperate in every way possible toward reasonable and prompt payments.

We can nevertheless see some of the handicaps under which he is working. Each state W. P. A. organization is supposed to handle its own compensation work and send the bills in to Washington for payment. However, it will be a long time before the W. P. A. becomes an efficient organization; and Dr. Stewart has practically no field personnel to assist the states in organizing this work.

The fee schedule is to be "not in excess of the minimum charge prevailing in the community for similar services". We interpret this to mean the usual minimum fees we would charge in an industrial compensation case in this State. After considering the subject of a fixed fee schedule with representatives of the A. A. A., the commission wisely decided not to publish such a schedule because of the many objections to it. Instead, it has tried to gather relative fee schedules from as many sources as possible, and have made up a private schedule for its own reference.

It is imperative for the physician, if he wishes fair consideration of his bill, to explain what his charges are for, with its careful itemization.

No reduction of over 10 per cent on a doctor's bill will be made by an auditor without having it O. K'd by one of the doctors of the Commission; and a letter of explanation will accompany such payments. If the doctor is not satisfied, the Commission will be very glad to consider the explanation of the physician; but there is no appeal from the decision of the Commission.

We suggested that, in order to make this method of payment satisfactory from our point of view, it was very important to have a cooperating committee of each State Medical Society assist in checking doubtful bills, and in adjusting complaints. This may possibly be done, but it will depend on the coöperation between the State Society and the local W. P. A. office. Dr. Stewart assured us that, at the present time, he is receiving practically no complaints.

We quote extracts from the *rules and regulations of the Commission,* dated July 15, 1935, regarding W. P. A. cases:

2. The benefits authorized by the Emergency Relief Appropriation Act of 1935 extend only to cases arising out of traumatic injury to an employee of the Works Progress Administration while such employee is engaged in the performance of duty for which he is receiving security payments.

4. Administration of the Act invested in the United States Employees' Compensation Commission, Washington, D. C. There is no statutory authority for review of the decision of the Commission in respect of a claim.

6. All reports, claims, vouchers or communications in regard to compensation should be sent from the office of the local or District Works Progress Administration to the Commission through the State Compensation Officer.

8. Employees of the Works Progress Administration who suffer a traumatic injury while in the

performance of duty, are entitled to medical and hospital care made necessary by reason of such injury.

9. The Compensation Act provides that medical treatment shall be furnished by United States medical establishments where practicable.

10. In locations where Federal medical facilities are not available, the State Compensation Officer or his local representatives should make arrangements for medical care by reputable private physicians. State Compensation Officers will inform physicians that the Commission will pay medical fees at rates not in excess of the minimum charge prevailing in the community for similar services. The State Compensation Officer or his local representatives should contact the local Medical Societies to enlist their coöperation. Plans should be made to distribute compensation cases among physicians in as equitable a manner as possible. A cumulative list must be kept by the local representative to show the number of cases referred to each physician.

18. No hernia operation should be authorized by the State Compensation Officer, but should be reported to the Commission for handling, *except*, that in an emergency due to strangulation or incarceration, where it is clear that the complication is due to injury on a Works Progress Administration project, an emergency operation may be authorized locally.

21. Authorization for treatment, Form CA-16, should be issued on the date of the injury or date employee applies for treatment and sent to the physician at the time the employee is referred for treatment. Emergency cases may be referred for treatment before issuance of Form CA-16, provided this form is issued within forty-eight hours thereafter.

23. Attending physicians are authorized to engage special nursing service where such special care is absolutely essential. Necessity for special nursing must be shown in each case.

26. Vouchers from physicians on Form S-69 should be submitted when the employee is discharged from treatment except when hospitalization or treatment extends more than thirty days, in which event voucher Form S-69 should be submitted at the end of each thirty-day period with a complete report from the attending physician showing the condition of the employee, the diagnosis and prognosis, and recommendations with reference to any future medical care.

27. Vouchers (Form S-69) should be verified by the signature of injured employee.

27 (d). Hospitals and physicians must not submit a voucher combining the services of both.

29 (a). All charges must be itemized to show specific dates on which treatments were rendered, the charge for each and a concise description of the injury for which the treatment was rendered.

(b) X-ray charges must be itemized as described in paragraph 28 (c).

(c) Joint accounts cannot be authorized for payment.

(e) Vouchers from physicians which include a separate charge for drugs must show whether such drugs were supplied from personal stock.

30. Each voucher Form S-69 must be supported by proper written authority authorizing such service unless such authorization has previously been forwarded to the Commission.

NUMBER OF CHILDREN REPORTED BY PHYSICIANS AS RECEIVING FREE BIOLOGICALS SINCE JULY 1, 1935

DIPHTHERIA TOXOID

County	To Oct. 31	Month of November	Total to Nov. 30	Average per Month
Atlantic	53	6	59	11.8
Bergen	555	312	867	173.4
Burlington	49	106	155	31.
Camden	97	86	183	36.6
Cape May	111	3	114	22.8
Cumberland	302	2	304	60.8
Essex	1345	535	1880	376.
Gloucester	88	70	158	31.6
Hudson	7	2	9	1.8
Hunterdon	1	7	8	1.6
Mercer	48	9	57	11.4
Middlesex	215	66	281	56.2
Monmouth	72	10	82	16.4
Morris	205	9	214	42.8
Ocean	5	1	6	1.2
Passaic	817	431	1248	249.6
Salem	60	21	81	16.2
Somerset	65	6	71	14.2
Sussex	2	0	2	.4
Union	784	114	928	185.6
Warren	109	7	116	23.2
Totals	4990	1833	6823	1364.6

SMALLPOX VACCINE

County	To Oct. 31	Month of November	Total to Nov. 30	Average per Month
Atlantic	88	11	99	19.8
Bergen	379	112	491	98.2
Burlington	151	27	178	35.6
Camden	289	33	322	64.4
Cape May	139	3	142	28.4
Cumberland	349	5	354	70.8
Essex	1149	508	1657	331.4
Gloucester	341	58	399	79.8
Hudson	2	0	2	.4
Hunterdon	15	0	15	3.
Mercer	56	10	66	13.2
Middlesex	421	48	469	93.8
Monmouth	50	7	57	11.4
Morris	505	143	648	129.6
Ocean	13	1	14	2.8
Passaic	1265	95	1360	272.
Salem	116	9	125	25.
Somerset	116	6	122	24.4
Sussex	5	0	5	1.
Union	1536	197	1733	346.6
Warren	217	0	217	43.4
Totals	7202	1273	8475	1695.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

December				January 1936			
3	Camden	12	Passaic	7	Camden	14	Bergen
3	Hudson	12	Somerset	7	Hudson	14	Cumberland
10	Bergen	13	Atlantic	8	Mercer	15	Middlesex
11	Mercer	13	Salem	8	Ocean	16	Gloucester
11	Ocean	18	Middlesex	9	Burlington	21	Warren
11	Union	19	Gloucester	9	Essex	22	Monmouth
12	Burlington	19	Morris	9	Passaic	28	Hunterdon
12	Essex	25	Monmouth	10	Atlantic		Sussex

ATLANTIC COUNTY

Robert A. Kilduffe, Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Hotel Shelbourne November 8, 1935, Dr. C. C. Charlton presiding and seventy members present.

A letter of thanks for flowers was received from the family of the late Dr. H. W. Laurence.

The bill for Chamber of Commerce dues in the amount of $20 was ordered paid.

Mr. W. L. Moise requested and urged the 100 per cent enrollment of the Society in the American Red Cross.

SOCIAL SECURITY ACT

Dr. L. A. Wilkes, Executive Officer of The Medical Society of New Jersey, spoke briefly on the effect of the Social Security Act on the practice of medicine in this State, and demonstrated the method used to inform the public of the functions and activities of the State Society.

NEW MEMBERS

The Board of Censors recommended the applications of Drs. W. W. Hersohn, Lillian Le Kites Wallis and Henry Ruffu, all of Atlantic City, and Dr. Frazier Elliott, of Hammonton, and they were elected to active membership.

HEALTH MEETING

The members were urged to attend the Health Meeting in the High School Auditorium on November 14, 1935, which is being conducted under the auspices of the Chamber of Commerce and the Atlantic County Medical Society.

INVESTIGATION OF MEDICAL PRACTICE

Dr. H. S. Read made a motion that a committee be appointed to investigate the abuse of medical practice in this county, this committee to be composed of the President and Vice-President with seven other members. This committee is directed to investigate for twelve months the use of clinics; hospital ward admissions, Red Cross, and Welfare and other organizations in Atlantic County, and to report its findings to the Society at the expiration of that time. The motion was passed.

AUTOMOBILE INSIGNIA

Dr. Scanlan spoke of the provision of identifying insignia for the members' automobiles, and mentioned the plan of the Philadelphia County Medical Society where only members are given such identification. This excludes nurses, dentists and osteopaths, etc., from using these insignia.

NOMINATING COMMITTEE

The following members were appointed to the Nominating Committee: Drs. E. H. Harvey, H. S. Davidson, C. M. Fish and C. H. deT. Shivers.

SCIENTIFIC

The scientific paper was presented by L. G. Rowntree, M.D., Director of The Institute for Medical Research, Philadelphia, who spoke upon "Endocrine Therapy".

As an introduction to the subject, Dr. Rowntree commented that no finer nor more valuable work could be recalled than the relatively recent studies of the chemistry of the endocrine glands, much of it having been carried on in the United States. The work of American biologists and chemists, as also of American physiologists, has been outstanding; but unfortunately, the clinician, in his interest as well as his understanding and application of the advances which have been made, has lagged far behind.

Dr. Rowntree emphasized, however, that so far-reaching is the relation of endocrinology to the study of disease, a relation as yet apparently only in its infancy, that every clinician must inevitably develop more or less familiarity with it if he is to keep abreast of the developments in his profession.

Dr. Rowntree then gave a most thorough and comprehensive, as well as a most interesting, review of recent advances in endocrinology, endocrinopathy, and endocrine therapy. The paper was of absorbing interest and greatly enjoyed by all who were privileged to hear it.

The paper was briefly discussed by Drs. A. Westney, S. L. Salasin and R. A. Kilduffe.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at the Holy Name Hospital, Teaneck, on November 12th. The minutes of the October meeting were read and approved.

NEW MEMBERS

The following were elected to membership:

Regular—
Dr. Joseph A. Latona, Lodi
Junior—
Dr. V. De Biaso, Rutherford
Dr. Robert J. Neville, Hackensack

The following applications for membership were read:

Junior—
Dr. Vincent P. Candio, Lyndhurst
Dr. Edward V. Sexton, Teaneck
Dr. G. Albin Liva, Wyckoff
Associate—
Dr. William A. Kellogg, Teaneck.

COMMUNICATIONS

A letter from Dr. A. J. Casselman announcing a Conference of Venereal Disease Workers to be held at the Mountainside Hospital of Montclair on the morning and afternoon of Tuesday, November 19th.

A letter from Dr. L. A. Wilkes announcing the approval of the Medical-Dental Service Bureau which was being organized by the Essex County Medical Society.

A card from the Tuberculosis and Health Association announcing a meeting at the Dwight Morrow High School at 8 p. m. Wednesday, November 13th.

Two letters from Mr. William H. Brindle, Jr., Secretary of the Bergen County Police, inviting the Bergen County Medical Society to be represented at the dinner in honor of Judge J. Wallace Leyden. The letter written by Dr. David Corn, our President, was approved.

NEW BUSINESS

Mr. F. E. Whitehead had on hand several copies of the 1935 Roster of the Bergen County Medical Society which he had prepared and succeeded in paying for by advertisements. He announced that copies were available to any member.

He also announced that tickets were available for the dinner of the Bergen County Medical Society in honor of Dr. E. E. Conover to be held at the Swiss Chalet on November 21st at 8 p. m.

He also announced the American Medical Association radio programs heard over the National Hook-up at 5 p. m. on Tuesdays.

Dr. A. Liva stated that the Bergen County Bar Association contemplated holding a meeting at which some prominent authority would speak on the legal aspects of the use of narcotics, and that the Bergen County Medical Society would be invited to attend. Dr. D. Goldberg moved that the Society accept the invitation of the Bar Association.

Dr. S. T. Snedecor mentioned two proposed W. P. A. projects of the State Medical Society, and the action of The Medical Society of New Jersey requesting the American Medical Association to call a winter meeting of its House of Delegates to take definite action on the proposed National Health Insurance.

SCIENTIFIC PROGRAM

Dr. Thomas H. Russell, Associate Surgeon, Post-Graduate Hospital, and Surgeon, New York and Gouverneur Hospitals, spoke on "Post-Operative Complications and Their Management". After mentioning the importance of blood chemistry determinations, choice of anesthetic and the value of blood transfusions in preparing a patient so as to avoid complications, he gave an excellent presentation of the complications that a surgeon should always guard against; some of which were atelectasis, pulmonary embolism and infarction, pneumonia, postoperative gastric dilation, tympanites and gas pains, paralytic and mechanical ileus, peritonitis, hiccoughs, evisceration, pyelitis, cardio-renal complications, bladder distention, phlebitis, brachial and ulnar palsey, alkalosis, postoperative sinuses and fistulae, wound infections and hemorrhage.

He gave many important suggestions to aid in the diagnosis and treatment of these conditions.

His paper was discussed by Dr. Markham and Drs. Burnham, Corn and Farmer.

Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey, spoke upon the "Organization and Functions of the State Medical Society". Dr. Wilkes explained the legislative, executive and judicial organization and functions of the Society and presented slides showing the active leadership of the State Society in initiating programs vitally important to the public and to the medical profession, and in promoting such programs through the County Societies through 900 members active in County and State Society committees.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The 106th annual meeting of the *Burlington County Medical Society* was held at the Moorestown Field Club, Moorestown, N. J., on Thursday evening, November 14, 1935.

Following the recommendations of the Executive Committee, it was decided to continue to hold the meetings in the evening rather than in the afternoon. This change in the past year has proved to be a very helpful one, judging from the increased attendance and interest in the meetings. Other recommendations by the Executive Committee were an increase of dues to $20 a year, the election of a Program Committee, the revision of the Constitution and By-Laws in such a manner as to bring them up to date, and the appointment of a committee to consider possible legislation concerning social security acts. These were all passed on favorably by the Society.

PROGRAM COMMITTEE

The new Program Committee will consist of four members elected by the Society. Two of these mem-

bers will be changed each year. The chairman, the fifth member of the committee, is to be appointed by the President each year. It shall be the duty of this committee to arrange for the scientific programs at the regular meetings, also to arrange for whatever social and entertainment features are necessary for these meetings. The Treasurer's annual report was approved and accepted.

NEW MEMBERS

Dr. William E. Bray, of Pemberton, and Dr. John B. Clement, of Beverly, were elected to membership in the Society.

PRESIDENT'S ADDRESS

President J. Howard Hornberger made no formal address as is the custom at the annual meeting, but he did give a more or less impromptu speech in which he stressed particularly close coöperation and united effort on the part of each individual physician with the County Society. This, he stated, he considered most important in these times of change. Contrary to the usual custom of not reëlecting the same President for the second consecutive term, it was felt advisable to continue Dr. Hornberger's term of service another year, inasmuch as he had led the Society to the completion of its most successful year.

ELECTION OF OFFICERS

The following officers were elected for the coming year:

President, J. Howard Hornberger
Vice-President, J. Lester Small
Secretary, George T. Tracy
Treasurer, E. Vernon Davis
Reporter, Parry M. Scott.

SOCIAL

Following the business session, a very interesting social and entertainment period was enjoyed by all.

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

The Fifty-second Annual Meeting of the *Cape May County Medical Society* was held at the Hotel Bellevue, Cape May Court House, on Tuesday, November 19, 1935, at one o'clock p. m.

The following members were in attendance: Drs. Brooks, Corson, Crowe, Cryder, Dandois, Friedland, Haines, Hollinger, Hornstine, Hughes, Pettit, Pressman, Robbins, Townsend, Tomlin, C. W. Way and E. Way—total 17; absentees, 9.

The following visitors were also present: Drs. Darnall, Read, Brown and White, of Atlantic City; Campbell and Diverty, of Woodbury; Wilson, of Bridgeton; Kain, of Camden; Bennett, of Millville; the Executive Officer, Dr. LeRoy Wilkes, Trenton, and Professor E. J. G. Beardsley, of Philadelphia.

ELECTION OF OFFICERS

The following were elected officers for the year 1936:

President, John B. Townsend
Vice-President, Hurlbert H. Tomlin
Secretary and Reporter, Warren D. Robbins
Treasurer, H. H. Tomlin.

Member of Nominating Committee of State Society, Clarence W. Way.

Delegate to State Medical Society for term of three years, Clarence W. Way; Alternate, Frank R. Hughes.

Censor for three years, Allen Corson.

The following committees were appointed:

Emergency Relief

W. P. Haines — F. R. Hughes
C. W. Way — G. F. Dandois
M. Cryder — John B. Townsend

Public Health

Aldrich C. Crowe — A. J. Friedland
H. H. Hornstine

Welfare

Herschel Pettit — G. F. Dandois
Oscar Ziegler

Post-Graduate

Clarence W. Way — C. Eugene Darby

Legislation

Allen Corson — G. F. Dandois
Millard Cryder

Liaison

C. Eugene Darby — Julius Way

Executive

Warren D. Robbins — E. S. Hallinger
H. H. Tomlin

Maternity

John B. Townsend — F. R. Hughes
Margaret Mace

Credit Bureau

George M. Brooks — J. H. Whiticar
H. H. Tomlin

The chairmen of the various committees were then called on for reports.

COMMITTEE REPORTS

Dr. Way reported for the Post-Graduate Course, stating that it was the best yet given, and that the percentage of attendance from Cape May County was the highest of any county in the State. All other committee chairmen reported "progress".

MATERNITY HOMES

The Secretary reported that applications had been made to the Medical Society to conduct maternity homes in the county as follows:

Mrs. Ada Applegate, on Shore Road at Cape May Court House, for the care of two patients.

Mrs. Martin Long, at 132 North Montgomery Avenue, Wildwood, for the care of five patients.

Mrs. Ada Gibson, at R. F. D., Cape May City, for the care of one patient.

They have all been inspected by Mrs. R. W. Casper, of Cedarville, N. J., District Supervisor, and her assistant, Miss Annis Hand, of Cape May Court

House, who had given a report to the Secretary. Communications had also been received from Dr. J. Lynn Mahaffey, Director of Health, stating that all of the applicants had met with the requirements of the State Board of Health.

The applications were discussed by the members of the Society who had full knowledge of the homes referred to and voiced their approval. It was therefore on motion voted that the licensing of the applicants be approved by the Cape May County Medical Society.

SCIENTIFIC

President Robbins then introduced Dr. E. J. G. Beardsley, Professor of Medicine in Jefferson Medical College, who gave an address on "Efficiency in the Practice of Medicine".

Dr. Beardsley is a pleasing, fascinating and convincing speaker, and gave an address that will be of practical use in the daily routine of every physician who was fortunate enough to hear him.

He said the new generation of physicians lack the old-time personal touch formerly given to patients. The new "too scientific" attitude produces a psychological condition not always conducive to the good of the patient. He deplored State control of medicine, which would place the profession under the control of a committee of laymen and reduce all physicians to mere hirelings subject to the whim of bosses and politicians.

FOUR MEETINGS ANNUALLY

It was voted to hold four regular meetings of the Society each year.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

President A. Charles Zehnder presided at the meeting of the *Essex County Medical Society* held at the Academy of Medicine, Newark, Thursday evening, November 14, 1935. Dr. Zehnder announced the appointment of the following committees of the Society to serve during the ensuing year:

COMMITTEES

ECONOMICS AND PUBLIC RELATIONS

Edgar A. Ill, General Chairman

SECTION ON ECONOMICS

H. H. Satchwell, Chm.
H. C. Barkhorn
H. A. Brodkin
L. W. Brown
E. P. Cardwell
J. A. Clarken
H. N. Comando
S. W. Ebenfeld
E. W. Erler
J. I. Fort
A. J. Ganley
A. O. Godfrey
A. S. Harden
P. H. Hosp
L. W. Hughes
J. W. Hurff
Herbert M. Ill
L. G. Kirkman
J. H. Lowrey
W. J. Marquis
S. Muta
J. N. Pannullo
A. Parasi
F. W. Pinneo
L. Schneider
E. S. Sherman
C. M. Tirrell
H. G. VanDerVeer
H. R. Van Ness
W. H. A. Warner
F. C. Weber

SECTION ON HOSPITALS

E. W. Sprague, Chm.
H. G. Allen
F. A. Alling
C. W. Barkhorn
A. W. Bingham
J. J. Connolly
E. A. Curtis
M. Danzis
W. P. Eagleton
E. A. Flynn
J. F. Hagerty
F. R. Haussling
Edgar Holden
F. E. Hubbard
J. W. Hurff
C. MacArthur
O. A. Mockridge
R. J. Mullin
C. R. O'Crowley
C. L. O'Neill
J. R. Pavia
Guy Payne
J. V. Reilly
Geo. S. Reitter
E. P. Schaefer
B. J. Smith
G. W. Vannatta
E. H. Wilan

SECTION ON PUBLIC HEALTH

E. C. Klein, Jr., Chm.
C. C. Beling
F. A. Bien
J. A. Bocchini
C. R. Brown
W. P. Burpeau
R. N. Connolly
F. N. Carbone
C. V. Craster
C. H. Crystell
Joseph Gardam
G. J. Holmes
J. Levy
J. F. Masterson
O. G. Matheke
G. A. McLellan
W. D. Minningham
J. D. Moore
A. G. Pilch
F. A. Pringle
B. B. Ranson, Jr.
O. H. Roth
E. L. Smith
E. H. Snavely
A. Stahl
E. B. Stokes
H. A. Tarbell
T. Teimer
G. B. Verbeck
W. W. Wolfe

NOMINATIONS

E. W. Erler, Chm.
B. A. Furman
Chas. Rich
E. A. Seidmann
W. H. A. Warner

MEDICAL RELIEF ADVISORY

E. Z. Hawkes, Chm.
H. C. Barkhorn
M. Danzis
I. L. Farr
E. W. Ill
S. Muta
W. H. A. Warner

ILLEGAL PRACTITIONERS

J. A. Clarken, Chm.
R. N. Connolly
J. I. Fort
Geo. F. Hewson
S. B. W. Leyenberger
J. S. Lincoln
E. V. Parsonnet
H. H. Satchwell
E. Steiner

LUNG COMMISSION

R. H. Dieffenbach, Chm.
I. Applebaum
F. P. Carrigan
E. I. Dorn
I. I. Miller
J. Polevski
Chas. Rich
H. H. Satchwell

HEART COMMISSION

C. E. Teeter, Chm.
F. A. Alling
H. M. Ewing
L. Mancusi-Ungaro
E. A. Parsonnet
J. Polevski
H. H. Satchwell

MILK COMMISSION

E. G. Wherry, Chm.
A. R. Bianchi
F. W. Pinneo
R. H. Scott
Wm. H. Vail

GRIEVANCES

H. N. Comando, Chm.
Anthony Ambrose
Maclyn Baker
D. M. Cerone
J. A. Clarken
H. M. Ill
E. C. Klein, Jr.
C. M. Tirrell

WOMEN'S AUXILIARY

R. H. Scott, Chm.
D. A. Epler
K. C. Forsyth
P. H. Hosp
S. C. Keller
E. H. Snavely
Theo. Teimer
H. R. Van Ness

CREDENTIALS

H. Roy Van Ness, Chm.
F. J. McCauley
R. A. Schaaf
H. A. Schulte

MEMBERSHIP

Chas. F. Rathgeber, Chm.
M. C. Angelillo
G. Blackburne
Marcus T. Block
F. P. Carrigan
J. A. Clarken
W. D. Crecca
W. F. Grady
Edgar Holden
C. S. Janifer
L. G. Kirkman
L. Mancusi-Ungaro
H. A. Murray
C. M. Robbins
R. M. Rogers
J. W. Siegel
R. F. Tomec
F. E. Voorhees

WELFARE

Wm. H. Areson, Chm.
J. I. Fort
D. A. Kraker
J. B. Morrison
H. Roy Van Ness

MATERNAL WELFARE COMMISSION

B. A. Furman, Pres.
E. W. Erler, Vice-Pres.
R. T. Potter, Sec. Treas.
A. R. Bianchi
A. W. Bingham
G. A. Braun
R. J. Brown
W. L. Harrington
Gerald Hayes
Carl H. Ill
H. B. Kessler
James V. Lyons
E. W. Mieran
W. B. Mount
J. N. Pannullo
N. G. Price

FINANCE

A. Chas. Zehnder, Chm.
E. A. Ill
F. W. Pinneo
R. H. Rogers
H. R. VanNess

PHYSICAL THERAPY

J. I. Fort, Chm.
S. S. Bradford
J. J. Flanagan
H. H. Kessler
Jerome H. Samuel
A. G. Solk
G. H. Taylor
John E. Toye

TO STUDY ACUTE POLIOMYELITIS

Ellis L. Smith, Chm.
R. N. Connolly
L. W. Bagg
C. R. Brown
J. W. Gardam
S. A. Go'dberg
M. C. Gregory
F. W. Pinneo
E. W. Ripley

TO STUDY CANCER

H. B. Orton, Chm.
A. R. Ahel
Wm. H. Areson
C. F. Baker
L. W. Brown
Max Danzis
J. I. Echikson
Milton Friedman
John W. Gray
A. S. Harden
F. R. Haussling
J. W. Hurff
Edgar A. Ill
H. S. Martland
W. D. Minningham
C. R. O'Crowley
G. P. Olcott
C. A. Schneider
A. Yaguda
Jos. N. Wyatt

TO STUDY REPRESENTATION ON THE COUNCIL

John F. Condon, Chm.
A. Ambrose
H. N. Comando
W. D. Crecca
J. T. English
E. A. Flynn
R. D. Freeman
W. K. Pudney
F. C. Weber

COMPENSATION BILLS

D. A. Kraker, Chm.
C. G. Crane
H. H. Kessler

ENTERTAINMENT

R. J. Mullin, Chm.
G. A. Braun
J. I. Echikson
J. J. Foley
Wm. Grady
O. H. Roth
A. Sasso
E. A. Seidman

PUBLICATION

J. H. Bradshaw, Chm.
G. Blackburne
L. W. Brown
E. W. Erler
J. W. Hurff
F. W. Pinneo
E. N. Riggins

ETHICS

Wm. H. Areson
E. W. Sprague
J. F. Condon
A. C. Zehnder
Edgar A. Ill
H. R. VanNess

POST-GRADUATE INSTRUCTION

H. H. Satchwell, Chm.
C. W. Barkhorn
J. I. Fort
B. A. Furman
Stuart Z. Hawkes
E. C. Klein, Jr.
W. B. Mount
H. A. Murray
D. F. O'Connor
Sol Parent
M. Singer
M. Weiss

NECROLOGY

H. A. Tarbell, Chm.
E. G. Wherry
H. S. Connamacher

RADIO BROADCASTING

Alfred Stahl, Chm.
W. J. Donahue
D. A. Kraker
D. F. O'Connor
G. P. Olcott
E. LeRoy Wood

AUTOMOBILE EMBLEM

C. M. Tirrell, Chm.

CO-ORDINATION OF RESOURCES FOR MEDICAL CARE

Louis Schneider, Chm.
Wm. H. Areson
J. L. Buckley
E. P. Cardwell
F. S. Forte
A. S. Harden
F. W. Pinneo
E. B. Stokes

BOARD OF DIRECTORS OF MEDICAL-DENTAL SERVICE BUREAU

A. C. Zehnder, M.D., Ex-Of.
C. P. Crowe, D.D.S., Ex-Of.
A. L. Barry, D.D.S.
F. C. Bartleman, D.D.S.
H. N. Comando, M.D.
J. F. Condon, M.D.
T. W. Harvey, Jr., M.D.
Edgar A. Ill, M.D.
J. H. Lowrey, M.D.
W. B. Mount, M.D.
Matthew Rouse, D.D.S.
R. H. Rogers, M.D.
H. H. Satchwell, M.D.
J. W. Scott, D.D.S.
H. R. VanNess, M.D.
F. H. VanWinkle, D.D.S.

COUNCILOR

At the last meeting of the Council Dr. H. H. Satchwell was elected a Councilor to fill the unexpired term of Dr. H. Roy Van Ness. Dr. Van Ness left a vacancy in the Council when he was elected Second Vice-President of the Society at the October meeting.

PUBLISHING PROPOSALS FOR MEMBERSHIP

President Zehnder announced that the publication in the County Society Bulletin of the names that are before the Committee on Credentials is for the information of the Society members. The individuals so named have not as yet been passed by the committee, the Council or the Society. The purpose of the publication of the names in the Bulletin is to give each member an opportunity to advise the Credentials Committee or the Council of any pertinent facts about the applicants before they are considered for membership.

OFFICERS OF MEDICAL-DENTAL SERVICE BUREAU

Dr. H. H. Satchwell spoke to the Society on "The Progress of the Economic Security Plan". He gave a very interesting exposition and detailed description of the practical aspects of the new Medical-Dental Service Bureau that is being started by the Essex County Medical and Dental Professions. The Board of Directors of the Bureau will be a one per cent representation of the professions, viz: ten physicians and five dentists, in addition to the President of the County Medical and Dental Society. This Board has met and organized, electing the following officers: Edgar Ill, M.D., President; John Scott, D.D.S., Vice-President; H. H. Satchwell, M.D., Secretary; Robert H. Rogers, M.D., Treasurer.

The Medical-Dental Service Bureau will shortly be established in centrally located, rented office space in Newark. The overhead expense for rent, stationery, office salaries and so forth is estimated to be $600 per month, or $7,200 per year. Mr. Dexter, an experienced executive from the Washington, D. C., Bureau, will probably come to Newark to start the Essex County Bureau. It is planned to have the Medical-Dental Service Bureaus established throughout the country, as in Texas, Missouri, Washington, New Jersey, to be similar and uniform in method and operation, so that they may dovetail together, ultimately extending the service to all the populace and profession. The Essex County Bureau will serve as the trial unit and nucleus for New Jersey.

Attention was directed to the fact that while this plan originated with the medical and dental professions in Washington, D. C.; and that it has no connection with the National Government or Administration. It is controlled and operated exclusively by physicians and dentists.

The cost of operation will be met by the service charge of 10 per cent of the professional fee involved. Thus, if assistance is rendered by the Bureau in a case where the doctor's fee is $150, the Bureau would receive $15, leaving $135 for the doctor. The patient pays no fee. It will readily be seen that doctors must utilize the Bureau to make it self-supporting by referring patients to be helped

by the Bureau's services, at least to the extent of aggregate fees involved of $6000 per month, or $72,000 per year.

The Academy of Medicine of Northern New Jersey

The programs of the meetings of the *Academy of Medicine of Northern New Jersey* during December, 1935, are as follows:

Monday, Dec. 9. Section on Eye, Ear, Nose and Throat. Clinical Meeting at the Eye and Ear Infirmary, Newark.

Tuesday, Dec. 10. Section on Medicine and Pediatrics.

1. Mesenteric Vascular Occlusion, Manfred Kraemer, M.D. Discussion, George Blackburne, M.D.
2. Control of Blood Thyroxine, Alfred Pennington, M.D.

Tuesday, Dec. 17. Section on Surgery.

1. Differential Diagnosis of Carcinoma of the Breast, Edward J. Ill, M.D. Discussion by E. Zeh Hawkes, M.D., and John F. Hagerty, M.D.
2. Treatment of Carcinoma of the Breast, Edgar Ill, M.D. Discussion by Fredrick W. Baker, M.D., and Milton Friedman, M.D.
3. Perforated Gastric Ulcer, Bernhard H. Greenfield, M.D. Discussion by Edward W. Sprague, M.D., and Albert S. Hardin, M.D.

Thursday, Dec. 19. Stated meeting, under the auspices of the Section on Obstetrics and Gynecology.

Endocrine vs. Non-endocrine Bleeding from the Uterus, Robert T. Frank, M.D., Mt. Sinai Hospital, New York.

(This meeting will be preceded by a conference of the members of all the Maternal Welfare Commissions of New Jersey held at the Essex House, 1048 Broad Street, Newark, at 4:30 p. m. Dinner at 7 p. m.)

Saturday, Dec. 28. Additional stated meeting of the Academy.

Surgical Treatment of Essential Hypertension, A. W. Adson, M.D., Mayo Clinic, Rochester, Minn.

The Academy will welcome any physician to its meetings.

Franklin J. Tobey, *Secretary.*

Anatomical and Pathological Society

The *Essex County Anatomical and Pathological Society* has honored Dr. Harrison S. Martland by the initiation of a yearly "Harrison S. Martland Lecture" to be given each year by some outstanding contributor to the science of medicine.

The first "Harrison S. Martland Lecture" will be held at the Academy of Medicine of Northern New Jersey, 91 Lincoln Park, Newark, New Jersey, on Saturday evening, December 14th, 1935. The program will consist of:

I. An introduction of the speaker of the evening, and some remarks about Dr. Martland by Dr. Emanuel Libman, of New York City.

II. The essayist of the evening will be Dr. George H. Whipple, Dean and Professor of Pathology at the University of Rochester, School of Medicine and Dentistry of Rochester, New York.

His subject will be "'Problems in Anemia". Dr. Whipple was a recipient of the Nobel Prize in Medicine.

Asher Yaguda, M.D.,
Chairman Program Committee.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held in the Homestead Coffee Shop, Woodbury, on the evening of November 21, 1935. The members present were: Drs. M. F. Lummis, W. J. Burkett, V. I. Barrows and I. W. Knight, of Pitman; Louis Ruttenberg, Mantua; Fuller G. Sherman, E. E. Downs, Ralph Moore, Harry Nelson, Duncan Campbell, H. B. Diverty and Dorothy Rogers, of Woodbury; Don Weems and R. D. Zapf, of Wenonah, and T. M. Gairdner.

NEW MEMBERS

Physicians elected to membership were as follows: Dr. Anthony J. DiMarino, of Paulsboro; Dr. Isaac N. Patterson, of Woodbury; Dr. Alfred G. Gillis, of Clayton; Dr. Ralph C. Venturo, of Glassboro, and Dr. R. D. Zapf, of Wenonah.

Dr. Charles Pedrick, of Glassboro, was made an honorary member of the Society.

PUBLIC HEALTH HOUR

A report of the Public Health Hour showed that for the first ten months there were 988 diphtheria immunizations and 450 smallpox vaccinations done in the county.

SCIENTIFIC

Dr. Don Weems, Wenonah, discussed the "Rational Treatment of Gastric Hemorrhage, with a Report on Three Recent Cases".

Dr. Fuller G. Sherman, of Woodbury, spoke on "Case of Myocardial Infarct, with Ruptured Heart".

Dr. Chester I. Ulmer, of Gibbstown, spoke on "Indigestion, Some Newer Methods of Treatment".

DATE OF ANNUAL MEETING

The Annual Meeting was changed to May from November, with present officers to continue until next May.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Jersey City Masonic Club, Wednesday, November 6, 1935, at 9:40 p. m.

Dr. T. J. Schuck, President, made a short inaugural address, in which he said: "Owing to the congestion of business at the last meeting, I now introduce myself as the new President of the Hudson County Medical Society. Under the efficient and diplomatic administration of my predecessor, Dr. E. J. Chapman, the accomplishments of this Society have been many. The program of medical broadcasts was inaugurated; the foundation of a medical

library was laid; a committee on economics was established; and new impetus was given to the vision of an Academy of Medicine in Hudson County. The Society will be glad to join me in giving a rising vote of thanks to Dr. Chapman.

"The result of the election is, of course, known to all of you. Some of us may have been disappointed at the outcome, and I know we all had personal friends on both sides of the ticket, but I believe that we all submit in a spirit of sportmanship to the theory of American Democracy, the majority rules.

"Our scientific program this year will devote one evening each month to one of the departments of medicine, beginning with pediatrics tonight, then general medicine, surgery, obstetrics, etc. We have secured speakers of well-known reputation, and hope to enlist many of the outstanding men in our County to take part in the meetings and discussions. The meeting on obstetrics promises to be especially interesting because the Staff of the Margaret Hague Hospital will have the floor and will not only present an account of the scientific work being done at that institution, but may also be able to clear up some points which have proved disturbing to a considerable portion of our membership.

"The Winter's program would not be complete without a discussion of Medical Economics; and for that meeting we have made a somewhat radical departure by inviting a speaker who is a strong propagandist for social insurance, Dr. J. Korem, of the Julius Rosenwald Fund. We have in the past heard several speakers opposed to any form of social medicine, and it seems only fair to give the other side a hearing. In extenuation of this step I may quote the remark credited to Voltaire: 'I disagree with every word you say, but I will give my life to give you an opportunity to say it.'

"Undoubtedly this paper will provoke a great deal of discussion. We hope to obtain several copies of this talk in advance, so that those men who are particularly qualified to discuss this question may properly prepare themselves.

"In other fields there is a good deal to be done this year. There are many questions of public health, of maternal welfare, and of post-graduate instruction that will require our attention. I am glad to say that during the short time in which I have been an incumbent of this office, I have received many stimulating and constructive suggestions from committee chairmen of great ability, executives, scientists, politicians, and orators. Men like Pollak, Evans, Cosgrove, Londrigan, Pyle, Quigley, Maras, Lange, Jaffin, Alter and others who should be able to organize the profession in this county in order that it may serve the best interests of the doctor, the patient and the public.

"I am happy and proud to be your presiding officer for the ensuing year."

President Schuck appointed the following chairmen of committees:

Publicity, T. A. Higgins
Post-Graduate Work, L. G. Lange
Membership, E. A. Peters
Scientific Work, B. S. Pollak
Welfare, Maurice Shapiro
E. R. A., J. L. Evans.

DIPHTHERIA IMMUNIZATIONS

Dr. B. S. Pollak, a member of the Welfare Committee of the State Medical Society, commented on the large number of cases of diphtheria and deaths in Hudson County as compared with the rest of the State; and also on the small number of immunizations that were given under the Public Health Hour. He introduced the following motion:

> Resolved, that the statistics regarding diphtheria in Hudson County and the immunizations given be referred to the Executive Committee for consideration and study; and that the report of the committee be made at a meeting of the Hudson County Society.

The discussion on the resolution was lengthy and animated and ended by the adoption of the resolution with but one dissenting vote.

EDUCATIONAL WORK IN THE MEDICAL CENTER

Dr. Pollak reported that the Medical Center would coöperate with a committee of the Medical Society for the purpose of developing its educational resources of the Hospital. On motion the subject was referred to the Executive Committee for action.

PUBLIC HEALTH WEEK

Dr. E. A. Jaffin, Chairman of the Public Health Committee, announced that the city would hold a Public Health Week beginning on November 18 and asked for the coöperation of physicians.

E. R. A.

There was a lengthy discussion of the relation of Hudson County to the E. R. A. Dr. E. J. Chapman, Chairman of the E. R. A. Committee, told of the favorable results of a conference of his committee with the Mayor and his advisers, and the development of a sentiment in medical and official circles to adopt the system.

SCIENTIFIC

The scientific paper of the evening was given by Dr. Murray Bass, Associate Pediatrician of Mount Sinai Hospital, New York City, on the subject "Unusual Forms of Rheumatic Infection in Children". The paper was discussed by Drs. J. L. Rosenstein, Nicholas Alter and G. Kerdasha.

Dr. LeRoy A. Wilkes, Executive Officer of the State Society, gave a talk on the work of the State Medical Society in the distribution of medical services. Film-slides containing the paragraph headings of his address were shown as he developed his subject.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* held its Annual Banquet at the Trenton Country Club on the evening of November 14, which was attended by a rather small percentage of the membership.

Dr. Roscoe West, of the N. J. State Teachers'

College, gave a most interesting description of his recent tour through Germany, detailing the present attitude of the German Nation with respect to educational programs based upon three cardinal principles,—courage, duty, and hope.

Dr. West brought many interesting photographs, which were shown in moving picture display.

President Cottone complimented the Treasurer, Dr. North, for a most successful supper, accompanied with a musical program rendered by a trio of star performers.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular monthly meeting of the *Morris County Medical Society* was held the evening of Thursday, November 21, at The New Jersey State Hospital at Greystone Park.

President Costello called the meeting to order with an attendance of about 140, this being an "open" meeting and there being present many guests, including representatives of the judiciary, the legal profession, utility corporations, and the engineering association of Morris County.

There being no objection, the routine procedure was suspended to make way for the speaker of the evening.

President Costello preceded his introduction by welcoming the guests and extending the courtesy of the floor for any questions they might wish to ask later; that we were fortunate in having with us a man who is identified with chemistry in New York University, and who for several years has been associated as toxicologist with the office of the Medical Examiner of New York City and has done much to increase and elevate the prestige of this office; whereupon Dr. Alexander O. Gettler was introduced and proceeded with his topic, "Toxicology in Medico-Legal Autopsy".

Dr. Gettler prefaced his scientific address by saying that in New York City the offices of coroner and county physician were displaced in 1918 by the office of the Chief Medical Examiner; that this office investigates, along scientific lines, all sudden and violent deaths by what generally is known as toxicology, and the application of chemistry, histology, bacteriology, serology, and photography; that all these should be used in cases of sudden death; that they do about 2400 bodies a year and that all told he with his assistants have analyzed over 40,000 human bodies.

Reflecting the high value of this work, the speaker referred to and detailed more than a dozen well-known and much publicised cases of sudden and violent deaths, showing how conviction for crime and murder could not have been possible without this scientific procedure; citing even a case where the essential corpus delicti could not possibly have been established, the body of a murdered wife having been buried and covered with quick lime so that the clothing and features were destroyed beyond recognition, except that analysis revealed in the stomach the same fruits and nuts that it was proven the victim had eaten in the home of friends shortly before she was murdered by her husband, who was convicted and went to the chair. He detailed other cases in which this science set aside entirely the outward apparent cause, and established beyond question the true cause of sudden death, thus leading to the conviction of the criminal who otherwise would have escaped on the assigned cause of death by a lay coroner or a physician not competent in this scientific work; and proving that chemical analyses will answer questions that otherwise could not be answered.

The speaker drew contrasts between the accuracy of chemical analyses and the crude and uncouth work of a lay coroner or the unreliable work of an unqualified physician. He pointed out the importance of this work being in the hands of competent pathologists and toxicologists, free from political appointment or interference. He cited the fact that Massachusetts prides itself in being the first to introduce the office of county physician; but unfortunately the district attorney is the boss there; and if he says there is to be no autopsy, there is none.

The speaker regretted that this scientific work is not followed in this country to any appreciable extent as it is in foreign countries and stated that even from far away Australia, where the system had been adopted, he had received letters of commendation. He further stated that he had started a class in toxicology at New York University, but that he doubted, under present conditions, the fulfillment of his hope that when these men have finished their course they would be absorbed somewhere in good positions as competent county physicians.

Dr. Gettler's address was heartily applauded and left no doubt of its importance to the large group of professional and lay listeners.

The evening closed with refreshments in the hospital cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the Valley View Sanatorium, Paterson, N. J., on Thursday evening, November 14, 1935, at nine o'clock, Dr. MacMillan, President, presiding.

The Executive Committee called to the attention of the members that there seemed to be some tendency on the part of pharmacists to prescribe for patients. This procedure is unethical and should be investigated.

A motion was made to withdraw membership from the Paterson Chamber of Commerce. This was duly seconded and carried.

DATE OF ELECTION

A suggestion was made that a change in our date of electing and installing officers would be desirable by the State Society. This change would consist of the election of officers in May and their installation in June. The matter was referred to the Committee on By-Laws.

NEW MEMBERS

The following members having been favorably reported on by the Censors, were elected to Associate Membership:

Dr. Arkad K. Biczak
Dr. Victor F. Desmet
Dr. John E. Leach

Transfer of membership from Alabama having been presented, Dr. M. D. Hogan was elected to Senior Membership.

SCIENTIFIC

Dr. Frank Berry, of Bellevue Hospital, New York, gave an excellent paper on "The Surgical Treatment of Pulmonary Tuberculosis". This included pneumothorax, phrenicotomy and thoracoplasty.

The second paper was an interesting resumé of the cases of pneumothorax performed at the Valley View Sanatorium. It was read by Dr. E. L. Warren.

Dr. O. R. Hagen then spoke briefly on the functions of the tuberculosis agencies as educational propaganda which should be given the full support of the Medical Society.

SOCIAL

The members then adjourned to the spacious dining room of the sanatorium and were served an excellent steak dinner.

MEDICAL-DENTAL SERVICE BUREAU ADOPTED

Dr. MacMillan then called for a report of the Committee on the Coördination of Medical Care. Dr. Johnsen made the report that after an extensive study of the Washington Plan, the Committee had unanimously agreed to recommend its adoption. The following resolution was submitted for the consideration of the Society:

Resolved: 1. That we, the members of the Passaic County Medical Society, and the members of the Passaic County Dental Society approve the establishment of a Medical-Dental Service Bureau.

2. That the necessary sum, not to exceed two thousand dollars, be loaned by the joint societies to the Medical-Dental Service Bureau, Incorporated, as the share of the societies in setting up the Bureau.

3. That the Committee on Coördination of Medical Care, in conjunction with a similar committee from the Passaic County Dental Society, be empowered to inaugurate the Medical-Dental Service Bureau, Inc.

4. That the Medical-Dental Service Bureau be incorporated in the State of New Jersey under guidance of counsel for the Washington Medical-Dental Service Bureau.

Dr. Henry Cogan made a motion that the resolution be adopted. The motion was seconded by Dr. Morris Joseph and was unanimously adopted.

ADVANCE NOTICE

The Society of Surgeons of New Jersey will meet on January 15, 1936, in Jersey City. Clinics will be held in the afternoon at the Jersey City Medical Center. There will be no morning Clinics. Lunch will be served at the Jersey City Hospital about 1:15; and a 7 o'clock dinner will be served at the Carteret Club.

All members of County Societies are invited.

WALTER B. MOUNT, *Secretary.*

OBITUARIES

DR. R. M. A. DAVIS

Dr. Richard Miller Acton Davis, prominent physician of Salem for many years, passed away at his home on Market Street, on November 7, 1935, at the age of sixty-two years. He was a Trustee of The Medical Society of New Jersey and was at the meeting on November third. He was taken ill with a heart attack on the morning of the seventh, and died at ten o'clock.

Dr. Davis was born December 28th, 1873, in Mannington Township at what was known as the Green Hill Stock Farm. His parents were David E. and Esther C. (Miller) Davis. He received his early education in the Salem public schools and was graduated from the Medical Department of the University of Pennsylvania in 1896. He continued at Penn for a short time and then became an intern at Cooper Hospital, Camden, where he remained a year before coming to Salem, where he practiced during the rest of his life. He was active in the Salem County Medical Society and in The Medical Society of New Jersey. He was a pioneer in the movement for the Salem County Memorial Hospital. He was a member of the Medical and Surgical Staff and no one labored more to make the institution the valuable asset it is to the community today.

Dr. Davis was interested in and gave his support to everything that was worthwhile in this locality. At his death he was the President of the Gloucester-Salem Council Boy Scouts of America of which he was the organizer. The Boy Scouts never had a more enthusiastic worker for their cause.

The *Standard and Jerseyman* of November 7 said of him:

"The death of Dr. Davis removes from this community a man whose entire adult life has been given to high service. In the practice of his profession and in every civic duty he was called upon to perform, he was forthright and sincere to an unfaltering degree. Beneath a dignified manner, he carried a warm and sympathetic heart, and the charm of his true nature drew to him enduring friends."

THE WOMAN'S AUXILIARY

PRESIDENT'S CHRISTMAS GREETING

The days glide by, the weeks slip past, and the months roll on, bringing us to another Christmas season. May it bring to you all, peace, comfort, joy and happiness.

Occupied as we are with the pleasures and joys of the approaching Yuletide, when all the world turns to the Christ child, let us not forget the duty we owe to humanity and ourselves in furthering the interests and usefulness of the medical profession through the work of the Auxiliary.

The year swiftly passes and we should ask ourselves, "How much have we accomplished? and how much progress have we to report at our next Board meeting in January?"

We hear that Warren County is thinking of organizing an Auxiliary. We shall be proud and happy to welcome its members. What about the five remaining counties, namely, Cumberland, Hunterdon, Morris, Salem and Sussex? Let us hope that they too will be organized before the Annual Meeting in June,

Your President, in all sincerity, sends you this greeting:

I wish you all the joys of old,
And many that are new;
I wish you everything that will
Make Christmas bright for you.

MRS. FREDERICK A. KINCH,
President Woman's Auxiliary to
The Medical Society of New Jersey.

Atlantic County

Reported by Mrs. Samuel L. Salasin

The *Woman's Auxiliary to the Atlantic County Medical Society* met in the Pent House of the Hotel Shelbourne Friday night, November 8th, Mrs. Carl A. Surran presiding.

Those present were: Mrs. Charles Sinkinson, Jr., Mr. Arthur Chenoweth, Mrs. William L. Moise, Mrs. Herbert Rassatt, Mrs. Ronaly Manning, Mrs. David Weeks, Mrs. Ily R. Beir, Mrs. Joseph Marshall, Mrs. Bernard Crane, Mrs. J. Carlisle Brown, Mrs. G. Ruffin Stamps, Mrs. A. W. Westney, Mrs. Percy Clark Joy, Mrs. David B. Allman, Mrs. Adrian Wychgel, Miss Jane Wychgel, Mrs. Daniel Reyner, Mrs. E. G. Shreve, Mrs. Peter Marvel, Mrs. A. G. Malamut, Mrs. Edw. H. Dyer, Mrs. E. H. Harvey, Mrs. Barney Barab, Dr. and Mrs. Alfred Westney, Mrs. Hubert Somers, Mrs. Zeph Conover, Mrs. Carl Surran, Mrs. Rogert Bradley, Mrs. Emanuel Mally and Mrs. Samuel Salasin.

Dr. Hilton S. Read gave an address on *Socialized Medicine.* He emphasized the fact that the last Congress had passed a Social Security Bill which will affect every State in the Union and will be the first card of the New Deal Administration. The medical profession should support an organized defense of medicine. The great quarrel is over the distribution of medicine. The State of New Jersey has taken care of its indigent, and also boasted of its progress in diagnosis and therapy. These great foundations, such as Rosenwald's and Borden's, are the ones which are undermining the medical profession. Research medicine has stopped in Germany with socialized medicine. Patients are assigned to a physician through the votes he has brought to the polls, and each doctor is given a certain geographical area. Their treatment of medicine is as follows: Line great numbers of patients up in an office; everybody with colds or headaches stand up.

Mrs. Chenoweth gave a very interesting talk on *The Medicine Garden.* Aristole was the first to cultivate plants for medicine. She spoke of the shrubbery H——— tale because it is so curiously pointed and a grass plant and was used by the Chinese for hay fever, now known as efedrin. Herbs were grown in monasteries and given to the indigent as medicine. Names of plants bring in folk lore. Chick weed is used for canaries; and ground up and mixed with lard it makes an ointment. Sorrels can be used for meat sauces; and its acid is healing to the kidneys. Myrtle is an evergreen leaf, and its flower, which looks like a violet, contains an acid like insulin. Dandelion contains a small quantity of insulin. The leaves of a dandelion can be used in sandwiches, and in this way you may combine medicine with cookery. Oil of wintergreen comes from sweet birch and is used for headaches or rheumatic aches and pains in general. Strawberry leaves were used in olden times for dysentery; the juice of strawberries were used in early days by Egyptian ladies and the Romans as a skin bleach.

The term julep came from the Arabians. They were the first to sweeten medicine, which before had been thought to be no good unless it was made from the worst smelling and worst tasting plants.

Mr. Moise, of the Red Cross, spoke briefly about the Red Cross Roll Call. He said that the Atlantic County quota is 5500 members, less than 5 per cent of the population.

Miss Betty Holoman played several beautiful piano selections.

A joint musicale and tea of the Beta Delphians and the Medical Auxiliary will be held at the home of Mrs. Clarence Whims, Ventnor and Surrey Avenues, Friday, December 6th, 3 p. m. to 5. The artists participating are Mr. William Stoking, Mr. Rudolph Hillelman and Mr. Leo Sack.

Burlington County

Mrs. M. M. Schisler, Reporter

The regular meeting of the *Woman's Auxiliary to the Burlington County Medical Society* was held at The Willows, Mount Holly, N. J., on Tuesday, October 1st, at 1 o'clock, with Mrs. J. Howard Hornberger, the President, in the chair.

Ten members were present; and two new members—Mrs. Carl Hogan, of Burlington, and Mrs. William W. Bray, of Pemberton—were elected.

The report of the Secretary and Treasurer was read and approved.

The program for the ensuing year was planned.

The meeting adjourned at 3 o'clock.

Essex County

Reported by Mrs. Herman C. H. Herold, Press Chairman

At a luncheon meeting of the *Woman's Auxiliary to the Essex County Medical Society* held in the Essex House on Monday, October 28, 1935, Dr. E. W. Sprague explained the attitude of the medical profession of the State of New Jersey toward Compulsory Health Insurance, and also spoke of the Washington Plan.

Starting with an explanation of Socialized Medicine as a free treatment of workers in the lower income brackets, he explained how the individual without income would still be treated gratis by the physician and surgeon, and how the State would pay a certain small sum only for those who are earning a low wage. He briefly explained the operation of Compulsory Health Insurance in England, mentioning some of the objectionable features.

Dr. Sprague explained also how Compulsory Health Insurance, or socialized medicine, precluded the free personal choice of the physician; that regimentation of the profession would ultimately be destructive of the best interests of the patient; and that we must preserve self-government in the physician-patient relationships. He brought out most definitely how very un-American socialized medicine or compulsory health insurance would be.

It was suggested that there is still danger of its being advocated as one of the possible measures of the New Deal, and warned the Auxiliary, as an association, and its members individually, to be ever on guard to prevent its being passed as a measure by the National Government. This measure, however, if passed by the National Government, would, undoubtedly, be put up to the States for individual adoption and in that fact lies the hope of the State of New Jersey.

To prevent the appeal of State Medicine in New Jersey, Dr. Sprague explained how the medical associations were taking up the plan now in use in Washington, D. C., calling it the *Washington Plan*, which provides for the budgeting of the payments for bills and fixed charges to doctors, dentists, and hospitals by patients; and which, combined with Hospital Insurance, should give to the middle class a greater degree of comfort in the payment of medical expenses.

Dr. Sprague then spoke of the excellent assistance of the Auxiliary in the work of the "Society for Widows and Orphans" of the State of New Jersey; and in the Health Hour project, and advised that there was much more work still to be done in both lines.

He called particular attention to the kind interest and great assistance which the Essex County Auxiliary is giving to the Benevolent Funds of the County Society. He then added that perhaps the most important work for the members of the Auxiliary to do individually and collectively is to assist in bringing about proper understanding of the relationship of the physician to the community, and of the reasons for the physician's viewpoint.

The second speaker on the program was Mr. Fred M. Rosseland, of the Newark Safety Council, who spoke on "Accidents in the Home", and said that falls, cuts, and burns caused the most serious results, in the order named. Mr. Rosseland gave most interesting statistics about different accidents.

Facts about the New City Hospital in Newark, which were to be given, were omitted from the program because of their political significance.

Gloucester County

Reported by Mrs. Henry B. Diverty

The *Woman's Auxiliary to the Gloucester County Medical Society* had a covered dish luncheon, followed by a business meeting, on Wednesday, October 2, at one p. m. at the home of the President, Mrs. J. Harris Underwood. There were fourteen members present.

Hudson County

Reported by Mrs. Joseph Murray

The *Woman's Auxiliary to the Hudson County Medical Society* held its regular monthly meeting at the Y. W. C. A. in Jersey City on Monday, November 4th, the President, Mrs. A. E. Jaffin, presiding.

Mrs. James Murphy, Chairman of the Public Relations Committee, gave out notices of the Dramatized Medical Hour being broadcast over WJZ every Tuesday at 5 o'clock to the representatives of various other clubs to be posted at their next meeting.

Mrs. Miles T. Long, Telephone Chairman, reported on the good work the telephone squad is doing in trying to urge the members to attend the meetings.

Mrs. Arthur Largay, Program Chairman, reported that Miss Mary Peters, Librarian at the Public Library in Bayonne, will give a book review on Anne Lindbergh's "North to the Orient" at either our December or January meeting.

Mrs. Louis Dodson, Chairman of Entertainment, told of a card party to be held on January 22, the place yet to be announced.

Mrs. Louis Perkel suggested that we edit a *Bulletin* two or three times a year with all the little breezy bits of news concerning the members of the Auxiliary and their families. Everyone was in favor of this, and Mrs. Perkel was unanimously elected Editor. She chose Mrs. Frank P. Nicholson as Associate Editor, and Mrs. Peter Maras as General Reporter. Other reporters representing the various vicinities in the county are Mrs. William Mulvihill, Mrs. Bernard Kelly, Mrs. Miles T. Long, Mrs. Robert Stockfisch and Mrs. J. J. O'Connor. Any member having any interesting bit of news is requested to get in touch with the reporters.

Mrs. Frank Nicholson gave a brief report of a State meeting held in the home of Mrs. Kinch, the State President. A lovely luncheon and a very fine talk by Dr. Sprague were enjoyed by all those present.

The business meeting then adjourned, and was followeed by two very interesting talks.

Mr. Dennis Sullivan, Chairman of the Health Program in Jersey City, spoke on "Health Today and Tomorrow". He outlined the work Jersey City is proposing to do in connection with the nation-wide health movement. The week of November 18th will be Health Week in Jersey City, and there will be intensive activities both in the schools and on the outside. The main event will be a public jury trial staged in the Snyder High School, with Judge Robert Kinkead presiding. Members of the Auxiliary will take part, and the public is urged to attend.

Dr. E. B. Sprague, of Essex County, a member of the State Advisory Committee, spoke on the problems concerning the Medical Profession arising from the economic changes due to the depression. He stated that the doctors are opposing socialized medicine because it brings a third party into a relationship that should exist only between doctor and patient. He mentioned that in several countries where this plan has been adopted, the economic status of the doctor is very poor. He also stated that health insurance takes care of the working man only, and not the poor.

He spoke of a plan which is being tried out in Washington, D. C., and seems to be very successful because it is trying to do what is best for the patient, the patient being the basic unit in the medical profession.

Dr. Sprague also suggested that we consider very favorably the "Widows' and Orphans' Fund" which we have here in Jersey.

A social hour followed, during which tea was served by Mrs. Henry Klaus and a group of hostesses.

Mercer County

Reported by Mrs. A. S. Fall, President

An all-day meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held on Tuesday, October 22, at the Municipal Colony. The morning was devoted to surgical dressing and luncheon was served at one o'clock. Talks were given by Mayor William J. Connor, Dr. A. S. Fell and Mrs. Anna N. Walker, who was hostess. There were forty members present.

DECEASED PHYSICIANS

Supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Henry R. Lawrence	78	Oct. 15, 1935	25 S. Illinois Av., Atlantic City	Same	Coronary disease of heart.
Edgar H. Ellis	76	Oct. 10, 1935	34 Beech St., Nutley	Same	Carcinoma of prostate. Arterio sclerosis.
Carlo F. Tommasi	67	Oct. 29, 1935	115 Lafayette St., Newark	Same	Coronary thrombosis. Bilateral pyonephrosis.
Eva K. Coffey	67	Oct. 31, 1935	Englewood San., Teaneck	Gladstone	General arterio sclerosis. Hemiplegia. Myocarditis.
Alfred Woodhouse	56	Aug. 3, 1935	Bristol, N. H.	Toms River	Chronic myocarditis. Hypertrophy.
Robert S. Sienering	32	June 5, 1935	Kingston, N. Y.	Newark	Acute myocarditis. Chr. endocarditis. Chr. nephritis.

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FRANK J. McLOUGHLIN, M.D. — MARCUS W. NEWCOMB, M.D.

EDWARD J. ILL, M.D. — J. BENNETT MORRISON, M.D.

EDITORIAL OFFICE

137 EAST STATE STREET, TRENTON, N. J.

PLAN OF THE INDEX

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1. Original Articles (scientific).
2. Authors of Original Articles.
3. Editorials.
4. State Society Activities.
5. County Society Activities and Reports.
6. Woman's Auxiliary.
7. Obituaries.

OFFICIAL LIST

The Official List of Fellows, Officers, Delegates, and Members, was published as a supplement to The Journal of April, 1935.

OFFICERS AND COMMITTEES

The Officers and Committeemen are listed in the advertising section of each issue of The Journal, from January to June on pages XX-XXII; from July to December, on pages III-V.

ANNUAL MEETING MINUTES

The minutes of the Annual Meeting and the House of Delegates are contained in the OFFICIAL TRANSACTIONS, which was issued as a supplement to the July issue, with its own index on the first page.

ANNUAL REPORTS

The annual reports of the Officers and Committees were printed in The Journal of April, 1935, pages 187-230, with its own index on page 231.

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Supplement to the Journal of the Medical Society of New Jersey, April 1935

THE N.Y. ACADEMY OF MEDICINE
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OFFICIAL LIST

OF THE

FELLOWS, OFFICERS, DELEGATES, AND MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1935

Prepared by J. Bennett Morrison, Secretary, assisted by the Secretaries and Treasurers of the County Societies.

This list is composed from the identical lists submitted by the Treasurers of the various County Medical Associations. If there are any errors in your name or address please take the matter up with the Treasurer of your County Medical Society and have the proper correction made so that the error will not be carried on next year.

The Alphabetical List is compiled in the office of the Secretary.

FELLOWS

Those marked with an asterisk are deceased

*Robert McKean 1766
*William Burnett 1767
*John Cochran 1768
*Nathaniel Scudder 1770
*Isaac Smith 1771
*James Newell 1772
*Absalom Bainbridge 1773
*Thomas Wiggins 1774
*Hezekiah Stites 1775

* * * * * *

*John Beatty 1782
*Thomas Barber 1783
*Lawrence Van Derveer 1784
*Moses Bloomfield 1785
*William Burnett 1786
*Jonathan Elmer 1787
*James Stratton 1788
*Moses Scott 1789
*John Griffith 1790
*Lewis Dunham 1791
*Isaac Harris 1792

* * * * * *

*Elisha Newell 1795

* * * * *

*Jonathan F. Morris 1807
*Peter I. Stryker 1808
*Lewis Morgan 1809
*Lewis Condict 1810
*Charles Smith 1811
*Matthias H. Williamson 1812
*Samuel Forman 1814
*John Van Cleve 1815
*Lewis Dunham 1816
*Peter I. Stryker 1817
*John Van Cleve 1818
*Lewis Condict 1819
*James Lee 1820
*William G. Reynolds 1821
*Augustus R. Taylor 1822
*William B. Ewing 1823
*Peter I. Stryker 1824
*Gilbert S. Woodhull 1825
*William D. McKissack 1826
*Isaac Pierson 1827
*Jeptha B. Munn 1828
*John W. Craig 1829
*Augustus R. Taylor 1830
*Thomas Yarrow 1831
*Fitz Randolph Smith 1832
*William Forman 1833
*Samuel Hayes 1834
*Abraham P. Hagerman 1835
*Henry Van Derveer 1836
*Lyndon A. Smith 1837
*Benjamin H. Stratton 1838
*Jabez G. Goble 1839
*Thomas P. Stewart 1840
*Fred S. Schenck 1841
*Zachariah Read 1842
*Abraham Skillman 1843
*George R. Chetwood 1844
*Robert S. Smith 1845
*Charles Hannah 1846
*Jacob T. B. Skillman 1847
*Samuel H. Pennington 1848
*Joseph Fithian 1849
*Elias J. Marsh 1850
*John H. Phillips 1851
*Othniel H. Taylor 1852
*Samuel Lilly 1853
*Alfred B. Dayton 1854
*James B. Coleman 1855
*Richard M. Cooper 1856
*Thomas Ryerson 1857
*Isaac P. Coleman 1858
*John R. Sickler 1859
*William Elmer 1860
*John Blane 1861
*John Woolverton 1862
*Theo. R. Varick 1863
*Ezra M. Hunt 1864
*Abraham Coles 1865
*Benjamin R. Bateman 1866
*John C. Johnson 1867
*Thomas J. Corson 1868
*William Pierson 1869
*Thomas F. Cullen 1870
*Charles Hasbrouck 1871
*Franklin Gauntt 1872
*Thomas J. Thomason 1873
*George H. Larison 1874
*William O'Gorman 1875
*John V. Schenck 1876

FELLOWS—Continued

*Henry R. Baldwin 1877
*John S. Cook 1878
*Alexander W. Rogers 1879
*Alexander N. Dougherty 1880
*Lewis W. Oakley 1881
*John W. Snowden 1882
*Stephen Wickes 1883
*Phanett C. Barker 1884
*Joseph Parrish 1885
*Charles J. Kipp 1886
*John W. Ward 1887
*H. Genet Taylor 1888
*Beriah A. Watson 1889
*James S. Green 1890
*Elias J Marsh 1891
*George T. Welch 1893
*John G. Ryerson 1893
*Obadiah H. Sproul 1894
*William Elmer 1895
*Thomas J. Smith 1896
*David C. English 1897
*Claudius R. P. Fisher 1898
*Luther M. Halsey 1899
*William Pierson 1900
*John D. McGill 1901
*Edmund L. B. Godfrey 1902
*Henry Mitchell 1903
*Walter B. Johnson 1904
*Henry W. Elmer 1905
*Alexander Marcy, Jr. 1906
Edward J. Ill 1907
*David St. John 1908
*Benjamin A. Waddington 1909
*Thomas H. Mackenzie 1910
*Daniel Strock 1911
*Norton L. Wilson 1912
*Enoch Hollingshead 1913
*Frank D. Gray 1914
*William J. Chandler 1915
Philip Marvel 1916
*William G. Schauffler 1917
Thomas W. Harvey 1918
*Gordon K. Dickinson 1919
*Philander A. Harris 1920
Henry B. Costill 1921
*James Hunter, Jr. 1922
Wells P. Eagleton 1923
*Archibald Mercer 1924
Lucius F. Donohoe 1925
James S. Green 1926
Walt P. Conaway 1927
Ephraim R. Mulford 1928
Andrew F. McBride 1929
George N. J. Sommer 1930
John F. Hagerty 1931
A. Haines Lippincott 1932
Frederic J. Quigley 1933
Lancelot Ely 1934

HONORARY MEMBERS

Those marked with an asterisk are deceased

*David Hosack, New York 1827
*John W. Francis, New York 1827
*John Condict, Orange, N. J. 1830
*Usher Parsons, Rhode Island 1839
*Reuben D. Murphy, Cincinnati 1839
*Alban G. Smith, New York 1839
*Willard Parker, New York 1842
*Valentine Mott, New York 1843
*Johnathan Knight, New Haven 1848
*Nathaniel Chapman, Philadelphia 1848
*John H. Stephens, New York 1848
*John C. Warren, Boston 1849
*Lewis C. Beck, New York 1850
*John C. Torrey, New York 1850
*George B. Wood, Philadelphia 1853
*Horace A. Buttolph, Short Hill, N. J. 1854
*Ashbel Woodward, Franklin, Conn. 1861
*Thomas W. Blatchford, Troy, N. Y. 1866
*Jeremiah S. English, Menalapan, N. J. 1867
*Stephen Wickes, Orange, N. J. 1868
*Samuel Oakley Vanderpool, Albany, N. Y. 1872
*Joseph Parrish, Burlington, N. J. 1872
*Ferris Jacobs, Lelhi, N. Y. 1872
*Charles A. Lindsley, New Haven, Conn. 1872
*William Pepper, Philadelphia 1876
*S. Weir Mitchell, Philadelphia 1876
*Cyrus F. Brackett, Princeton, N. J. 1880
*Joseph C. Hutchinson, Brooklyn, N. Y. 1880
*Thomas Addis Emmett, New York 1884
*Isaac E. Taylor, New York 1884
*D. Hayes Agnew, Philadelphia 1886
*Joseph Leidy, Philadelphia 1886
*Frederick S. Dennis, New York 1893
*John H. Ripley, New York 1893
*Virgil P. Gibney, New York 1893
*William Pierson, Orange, N. J. 1894
*Abraham Jacobi, New York 1896
*Virgil M. D. Marcy, Cape May City 1896
*Samuel H. Pennington, Newark, N. J. 1897
*Alfred A. Woodhull, Princeton, N. J. 1897
*J. Leonard Corning, New York 1902
*John Allen Wyeth, New York 1903
William K. Van Reypen, U. S. N. 1903
Lawrence F. Flick, Philadelphia 1903
S. Adolphus Knopf, New York 1906
*Albert Vander Veer, Albany, N. Y. 1907
Charles K. Mills, Philadelphia 1917
Richard C. Cabot, Boston 1917
George W. Crile, Cleveland, Ohio 1917
*John B. Deaver, Philadelphia 1917
*William J. Chandler, Lawtey, Florida 1923
Edward J. Ill, Newark, N. J. 1925
Joseph E. Raycroft, Princeton, N. J. 1930
Jackson B. Pellett, Hamburg, N. J. 1934

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JOHN F. HAGERTY, Newark	"	"	1936

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LOUIS C. LANGE, Weehawken	"	"	1937

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Scanlan, D. Ward	Gorson, Samuel
Shivers, C. H. deT.	Poland, Geo. A.
Stewart, Walter B.	Stern, Samuel

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Corn, David
Dezer, C. N.
Finke, G. W.
King, C. A.
Levitas, G. M.
Liva, A.
Littwin, Chas.
Hallet, F. S.
Huff, E. N.
Knowles, G. M.
Morrow, J.
Vroom, William
Wilson, H. B.
Trossbach, H.
Payne, J.

1933-34-35
Farla, M.
Hitzeman, L.
Black, L. W.
Barnes, Wm.

1934-35-36
Pallen, C. deS.
Toal, J.
Van Dyke, Joseph S.

1935-36-37
Farmer, Vincent
Vandersluis, H. H.
Edwards, J. B.
Irwin, J. H.
Tether, R. K.
Hull, D. B.
Markley, L. A.
Dilger, F. G.

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Haines, Edgar J.
Rodman, E. Warren
Tracy, George T.
Curtis, Howard C.
Darlington, Emlin
Imhoff, R. E.
Metzer, Emma P.

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Glover, L. L.
Hollinshed, Beulah
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Hummel, E. G.
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Jack, W. H.
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Lewis, Thomas K.
Roberts, Joseph E.
Fisher, Stella
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McCarthy, A. M.
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Wilson, L. R.

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Way, Clarence W.	Ziegler, O. F.

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Myatt, Leslie	Corson, E. S.
Walker, H. B.	Van Deusen, E. H.

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Beling, C. C.
Bingham, A. W.
Blackburne, G.
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Condon, J. F.
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Crecca, Wm. D.
Danzis, Max
Epstein, H. B.
Fort, J. Irving
Freeman, R. D.
Gennell, E.
Gray, John W.
Hanan, J. T.
Haussling, F. R.
Hawkes, E. Zeh
Hosp, Paul H.
Hurff, J. W.
Ill, Edgar A.
Ill, Chas. L.
Lowrey, Jas. H.
Martland, H. S.
McCauley, F. J.
Mitchell, A. J.
Mullin, R. J.
Orton, H. B.
Parker, J. E.
Payne, Guy
Pilch, A.
Pinneo, F. W.
Ranson, Jr., B. B.
Rathgeber, C. F.
Reissman, E.
Rich, Chas.
Snavely, E. H.
Sprague, E. W.
Stahl, Alfred
Allan, J. S.
Antonius, N. A.
Baldwin, S. H.
Barkhorn, H. C.
Blanchard, K.
Bianchi, A. R.
Broadnax, M.
Chamberlain, A. R.
Coburn, J. W.
Commando, H. N.
Crane, Chas. G.
Curtis, E. A.
Davies, G. W.
Devlin, Frank
Dieffenbach, R. H.
Echikson, J. I.
Emerson, L.
Flynn, E. A.
Harden, A. S.
Harvey, Jr., T. W.
Horsford, F. C.
Ill, H. M.
Keller, S. C.
Klein, Jr., E. C.
Kessler, H. H.
Kraker, D. A.
Levy, J.
Mancusi-Ungaro, L.
Marquis, D.
Matheke, O. G.
Menk, P. E.
Minard, E. L.
Morgan, Browne
Mount, W. B.
Muta, S. A.
Parsonnet, E.
Richardson, A.
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Satchwell, H. H.

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Tarbell, H. A.	Siegel, J. W.
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Van Ness, H. R.	Smith, Ellis L.
Wallhauser, H. J. F.	Toye, John E.
Weber, F. C.	Tutschulte, E.
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Chapman, E. J.	Daly, E. J.
Evans, Jas. L.	Dodson, L. W.
Hasking, A. P.	Doran, W. G.
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McLoughlin, F. J.	Koppel, Joseph
Nevin, John	Lupin, Edward
Niemeyer, C. V.	Madaras, J. S.
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Perlberg, H. J.	Mutter, A. A.
Pinkerton, W. A.	Perkel, L. L.
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Pyle, Louis A.	Shapiro, J.
Schwarz, B. T. D.	Sheeran, V. J.
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Stockfish, Robt.	Thum, Ernest
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Haggerty, D. L.	McCullough, J. H.
Hutchinson, A. D.	Pessel, J. F.
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North, H. R.	Sista, C. R.
Schildkraut, J. M.	Wilbur, W. L.
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McKiernan, R. L.	Kleiber, E.
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Wilentz, W. C.	Wetterberg, L. F.

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Disbrow, V. M.
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Manly, Thos.	MacGregor, A. W.
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Krans, E. S.	Currie, N. W.
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Ripps, M. L.	Knauer, G.
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Walsh, R. J.	Phelan, W.
Weigel, Elmer	Runnels, A. F.

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1935

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Reporter, Kilduffe, Robert A., Ventnor

Historian, Harley, H. L., Atlantic City

Censors, Davidson, Harold S., Atlantic City
Shivers, C. H. deT., Atlantic City
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Axilrod, Maurice, 2620 Pacific av., Atlantic City
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 109 States av., Atlantic City
Beir, I. R., Harvorford Apts., Atlantic City
Blampin, Winifred A., Galen Hill, Atlantic City
Bossert, Chas. A., 4021 Atlantic av., Atlantic City
Boysen, Theo. H., 100 Phila. st., Egg Harbor
Bradley, Robert A., 1616 Pacific av., Atlantic City
Brown, Carlisle J., 101 S. Indiana av., Atlantic City
Carrington, Wm. J., 905 Pacific av., Atlantic City
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Crane, Bernard, 306 Pacific av., Atlantic City
Dalton, S. Eugene, 1616 Pacific av., Atlantic City
Darnall, Wm. Edgar, 5 S. Morris av., Atlantic City
Davidson, Harold S., 1616 Pacific av., Atlantic City
Davis, W. Cole, 124 S. Illinois av., Atlantic City
deHellebranth, R. T., 104 S. Frankf't av., Ventnor
Durham, Robert B., 114 S. Illinois av., Atlantic City
Durham, Royal E., 114 S. Illinois av., Atlantic City
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Feinstein, Louis, 401 Pacific av., Atlantic City
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Henderson, K. P., 121 S. Illinois av., Atlantic City
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Hoffman, Harry S., 1902 Pacific av., Atlantic City
Holoman, M. Browne, 3 N. Granville av., Margate
Holt, Edward Z., Children's Seashore Home, Atl. C'y
Hudson, W. J., 39 W. Washington av., Pleasantville
Hyman, Chas., 1616 Pacific av., Atlantic City
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, John J., 1616 Pacific av., Atlantic City
James, Henry C., Mays Landing
Johnson, V. Earl, Medical Science Bldg., Atl. City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 905 Pacific av., Atlantic City
Kilduffe, Robert A., 5003 Atlantic av., Ventnor
Kline, Herman, 2627 Pacific av., Atlantic City
Krechmer, Abraham, 521 Pacific av., Atlantic City
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Lucas, Stanley L., 1600 Arctic av., Atlantic City
Mackler, Louis, 705 Pacific av., Atlantic City
Madden, Leland S., 21 E. Vernon av., Pleasantville
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 1710 Pacific av., Atlantic City
Marcus, Joseph H., 1148 Fifth av., N. Y. C., N. Y.
Marshall, Jos. C., 1517 Pacific av., Atlantic City
Martin, William, Hotel Ambassador, Atlantic City
Marvel, Philip, Jr., 101 S. Indiana av., Atlantic City
Mason, James H., 3rd, 1616 Pacific av., Atlantic City
Massey, John F., 20 S. Newport av., Ventnor
Merendino, A. G., 1616 Pacific av., Atlantic City
MeVay, James C., 2907 Pacific av., Atlantic City
Nickman, Harrison, 101 S. Newton av., Atlantic City
Olmstead, W. D., 515 Grammercy pl., Atlantic City
Pennington, John, 101 S. Indiana av., Atlantic City
Pilkington, Albert, Amsterdam Apts., Atlantic City
Poland, Geo. A., 206 Verona av., Pleasantville
Poland, Joseph, 1904 Pacific av., Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., Prof. Arts Bldg., Atlantic City
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, 507 S. Shore rd., Pleasantville
Roop, W. O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 1707 Pacific av., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Salasin, Samuel L., 511 Pacific av., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, Geo., 2900 Pacific av., Atlantic City
Senseman, Theodore, 3600 Pacific av., Atlantic City
Shenfeld, Isaac, 4806 Ventnor av., Ventnor
Shimer, A. Burton, 606 Pacific av., Atlantic City
Shivers, C. H., deT., 121 S. Illinois av., Atlantic City
Shivers, Chas. H., 121 S. Indiana av., Atlantic City
Shore, Ernest L., 37 S. New Jersey av., Atlantic C'y
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City
Smith, Andrew M., 344 Philadelphia st., Egg Harbor
Stamps, G. Ruffin, 214 E. Verona av., Pleasantville
Stern, Samuel, 2815 Pacific av., Atlantic City
Stevenson, A. M., 7506 Ventnor av., Margate
Stewart, Sloan G., 43 S. N. Carolina av., Atl. City

Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, 1616 Pacific av., Atlantic City
Timberlake, Baxter H., 1616 Pacific av., Atl. City
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Walker, Levi M., 110 N. S. Carolina av., Atl. City
Weiner, Samuel E., 904 Pacific av., Atlantic City
Wescott, Wm. C., Delaware & Pacific avs., Atl. City
Westney, Alfred W., 3005 Pacific av., Atlantic City
Whims, Clarence, 7117 Ventnor av., Ventnor
White, R. Rostin, 108 N. Trenton av., Atlantic City
Williams, R. A., Swarthmore & Atl. avs., Ventnor
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., Prof. Arts Bldg., Atlantic City
Wright, Elizabeth, 138 S. Penn. av., Atlantic City

Dental Associates

Phillips, C. Ferg, D.D.S., 1509 Pacific av., Atl. City
Steigerwald, Clarence S., D.D.S., J'cks'n&At.avs.,A.C.
vonDeilen, Arthur W., D.D.S., 1910 Pacific av.,A.C'y
Westcott, Eugene R., D.D.S., 1500 Pacific av.,Atl.C'y

Honorary Members

Forestier, Jacques, Aix-les-Bains, Savoie, France
Gehring, Gustave P., San Diego, Calif.
Ireland, Milton S., 23 S. Carolina av., Atlantic City
Lawrence, Henry R., Atlantic City
Marvel, Philip, Cleveland
Miller, D. J. M., 7209 Ventnor av., Ventnor
Reik, Henry O., Vermont Apts., Atlantic City
Reynolds, Walter, Atlantic City
Souder, Lewis R., 5 S. Victoria av., Ventnor

Transferred

Cooney, Chas. J., to Indiana State Med. Society
Roark, Jesse L., to Monmouth Co. Society

Number of active members and basis of representation, 116.

100 per cent paid up March 1, 1935.

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in January.

President, Corn, David, Ridgefield Park

Vice-President, Irwin, J. H., Englewood

Secretary, Knowles, George M., Hackensack

Treasurer, Markley, L. A., Teaneck

Reporter, Littwin, Charles, Englewood

Censors, the President, Secretary and Treasurer

Active Members

*Adams, Flora, Hackensack
Alexander, Samuel, Park Ridge
Anderson, R. M., Hackensack
Angelillis, P., Hackensack
Appold, George D., Bergenfield
Baketel, S. H., Jersey City
Baldwin, J. F., Bergenfield
Balze, H. R., Leonia
Barnes, J. William, Englewood
Barroso-Bernier, A., Englewood
Bell, J. Finley, Englewood
Berke, R. N., Hackensack
Black, L. W., Rutherford
Bleasby, C., Garfield
Blenkle, V. A., Teaneck
Bono, J., Northvale
Bookstaver, B. S., Teaneck
Bosch, T., Wycoff Township
Bregman, Alexander, Edgewater
Brennan, A. T. V., Tenafly
Brown, J. L., Grantwood
Buckley, P. J., Bogota
Burbank, H. E., Lyndhurst
Burnham, L., Englewood
Burns, G. C. H., Tenafly
Busicco, P. S., Englewood
Byers, C. W., Rutherford
Caldroney, T. L., Ridgefield Park
Campbell, J. M., Ramsey
Carrol, T. R., Hudson Heights
Clarke, Edward W., West Englewood
Cloud, A. W., Englewood
Cochrane, Cleland C., Closter
Connor, Clarence A., Fort Lee
Conover, E. E., Hasbrouck Heights
Conrad, E. K., Hackensack
Cooper, H. M., Rutherford
Corn, David, Ridgefield Park
Crandall, John K., Fort Lee
Cropsey, Charles D., Rutherford
Curtis, Donald, Hackensack
D'Agostin, Henry, Cliffside
Dayton, S. T., Englewood
Decker, J. G., Hasbrouck Heights
Demarest, J. W., Hackensack
Denig, R. D., Hackensack
DeSanto, A. M., Hackensack
Dezer, Chas. N., Jr., Hackensack
Dickson, J. D., Bogota
Dilger, F. G., Hackensack
Douglas, R., Englewood
Duffy, J. F., Westwood
Edwards, James B., Leonia
Ellmers, B. J., Paramus
Erickson, G. T., Hackensack
Essertier, Edward P., Hackensack
Farmer, Vincent, Hackensack
Farr, W. T., 288 Griggs av., Teaneck
Fessler, W., Grantwood
Fielding, William M., Allendale
Finke, George W., Hackensack
Finke, John H. D., Hackensack
Fisher, P. C., Ridgewood
Fitzhugh, W. F., Ridgefield Park
Fitzpatrick, L., 134 Bergen av., Ridgefield Park
Fliegel, William, Maywood
Fox, J. W., Hillsdale
Franklin, S. I., Englewood
Freeland, Frank, Hackensack
Garrett, Harry S., Park Ridge
Gershman, J. G., Dumont
Gilady, Ralph, Hackensack
Gillett, H. E., Ramsey
Gittlesohn, I., Hackensack
Gnasso, E. R., Fort Lee
Goldberg, David, Westwood
Goldfarb, A., Rutherford
Greenfield, A. W., Hackensack
Greenfield, W. J., Hackensack
Grimes, Jesse R., Dumont
Groff, P. A., Little Ferry
Hallet, Frederick S., Hackensack

Halpern, H. Englewood
Harney, J. N., Teaneck
Harryman, W. K., Hackensack
Hawes, V. L., Ramsey
Helff, J. R., Teaneck
Heller, G. H., Englewood
Hillsman, R. B., Teaneck
Hitzeman, L. A., 30 E. Passaic st., Maywood
Hoheb, A. S., Rutherford
Hoheb, K. R., Rutherford
Horowitz, H. J., Morsemere
Hubbard, S. F., Hackensack
Huff, Edmund N., Englewood
Hull, D. B., Ridgewood
Irwin, J. H., Englewood
James, W. L., Edgewater
Johnson, G. L., Englewood
Johnston, S. F., Rochelle Park
Johnston, R. O., Harrington Park
Jordan, W. L., Englewood
Jukofsky, I. D., Ridgefield Park
Kastler, F., Rutherford
Keir, Floyd E., Englewood
Kennedy, P. A., Englewood
Kenyon, H. M., Bergenfield
King, Chester A., Oradell
Kingslow, G. L., Hackensack
Knapp, Richard E., Hackensack
Knox, C. A., Ridgefield Park
Knox, Harriet L., Hackensack
Knowles, G. M., Hackensack
Kraissl, C., Englewood
Lamberto, V. A., 422 Stuyvesant av., Lyndhurst
Lansing, T. B., Tenafly
Lesko, S. W., Wallington
Levitas, Geo. M., Westwood
Legato, S., Cliffside
Lewis, Alice B., Saddle River
Littwin, Charles, Englewood
Liva, Arcangelo, 5 Pangborn pl., Hackensack
Liva, P. F., Lyndhurst
Luediecke, Rowland E., E. Rutherford
Lynch, M. M., Hackensack
*Lynn, J. V., Ridgefield
Lyons, R., Englewood
Macaulay, F. A., Teaneck
Mackellar, James M., Tenafly
McCormack, F. C., Englewood
McDonald, W. S., Tenafly
McIlvaine, W. E., Ridgefield Park
McFeeley, P. R., Bogota
McLane, A. D., Englewood
McLeod, H. J., Englewood
Mader, A. I., Hackensack
Markley, L. A., Teaneck
Mears, W. G., Leonia
Meyer, H. M., Hackensack
Moran, H., Englewood
Morrison, B. G., Woodridge
Morrow, J. R., Oradell
Mosher, H. L., Lyndhurst
Muller, F. L., Carlstadt
Mulligan, L. A., Leonia
Nicol, L. C., Bogota
Nichols, F. I., Hackensack
Netz, L. W., Hackensack
O'Brien, Paul, Rutherford
Paiien, C. deS., Rochelle Park
Patti, F. A., Leonia
Payne, Joseph, Midland Park
Pedeville, J., Palisade Park
Perham, R. G., Hasbrouck Heights
Pettit, H. H., Ridgewood
Phillips, Walter, Englewood
Pindar, I. D., Teaneck
Pindar, A. W., Teaneck
Prather, C. G., Westwood
Prather, J. W., Dumont
Proctor, James Wm., Englewood
Protzman, T. B., Englewood
Prout, Wm. B., West Englewood
Pullen, G. F., Leonia
Reich, S. B., Oradell
Reid, Erwin W., Garfield
Richardson, Charles A., Closter
Reinhold, H. E., Teaneck
Richie, E. W., Hackensack
Riordan, J., Rutherford
Robinson, S. E., Waldwick
Rowe, J. A., Ridgefield
Ruch, Louis, Englewood
Rucker, W. C., Hackensack
Ryley, H. W., Rutherford
Sandler, M., Fort Lee
Sarla, Michael, Hackensack
Schmidt, Walter W., Cliffside Park
Scullion, A., Cliffside
Sealy, H. J., Dumont
Seiler, B., Cliffside
Seymour, E. T., Tenafly
Smaine, E. C., Rutherford
Smith, B. A., Ridgewood
Snedecor, S. T., 50 Anderson st., Hackensack
Spiegelglass, A., Hackensack
Stuart, A. A. D., Ridgefield Park
Swayze, A. A., Hackensack
Taylor, H. W., Englewood
Teeter, John N., Englewood
Tennis, E. N., Tenafly
Tether, Russell K., Closter
Thompson, L. R., Morse av., Wyckoff
Tidwell, G. W., Wallington
Toal, Joseph, Ridgefield
Trossbach, H., Bogota
Tyson, Francis B., Leonia
Vanderbeek, S. W., Englewood
Vandersluis, H. H., Park Ridge
Van Dyke, Joseph S., Palisades Park
Van Winkle, C. I., Rutherford
Vita, F. J., Grantwood
Vroom, W. L., Ridgewood
Walsh, T. M., Hasbrouck Heights
Ward, Alfred W., Demarest
Ward, G. Harold, Englewood
Warren, Charles B., Bergenfield
Webb, Wilson D., Hackensack
Werner, G. H., Englewood
Whitman, L. B., Bergenfield
Whittacker, N., Hackensack
Widitsky, A., Paterson
Williams, W. C., Rutherford
Willis, B. P., Rutherford
Wilson, H. B., Hackensack
Winter, G., Teaneck
Witkoff, B., Woodridge
Wolowitz, Harry B., Hackensack
Worcester, George F., Englewood
Wry, Orlin V., E. Rutherford
Wurts, Margaret M., Englewood
Yachnin, S., Lyndhurst
York, J. L., New Milford

Honorary Members

Bell, J. Finley, Englewood
Clock, Ralph O., New York City
Lansing, T. B., Tenafly
*Pratt, John E., Dumont
Riordan, J., Rutherford
Swayze, A. A., Hackensack

Associate Members

Burtin-Opitz R., Palisade
Colonna, P. C., Englewood
Denison, C. W., Ridgewood
Harreys, C. W., Ridgewood
Inge, G. L., Englewood
Liddy, F. J., Mahwah
Payawall, J. L., Ramsey
Randazzo, A. P., Garfield
Spickers, W., Paterson

Received on Transfer

Liefield, W. L., from New Castle Med. Society

Transferred to

Bosch, Calvin C. F., to Iowa State Med. Society
Smith, Carroll D., to Passaic County Society
Stevenson, Geo. S., to Monmouth County Society

Number of active members and basis of representation, 223.

Associate members 9.

100 per cent paid up on March 1, 1935.

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Thursday evening of each month. Annual Meeting in November.

President, Hornberger, J. Howard, Roebling

Vice-President, Small, E. Lester, Medford

Secretary and Treasurer, Traey, George T., Beverly

Reporter, Shipps, Hammel P., Delaneo

Censors, Anderson, R. D., Burlington
Conroy, John S., Burlington
Hunter, Edward R., Delaneo

Active Members

Anderson, Richard D., Burlington
Bauer, Harry W., Palmyra
Busansky, Samuel T., New Lisbon
Conroy, John S., Burlington
Curtis, Howard C., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, Vincentown
Davis, Jacob M., Burlington
Downs, Roseius I., Riverside
Fahrenbruch, F. D., Mt. Holly
Geary, Russell D., Riverside
Haines, Edgar J., Medford
Haldeman, Robert E., Mt. Holly
Hartman, Luther, Maple Shade
Hogan, Carlton P., Burlington
Hollingshead, Lyman B., Pemberton
Hornberger, J. Howard, Roebling
Hunter, Edward R., Delanco
Imhoff, Robert E., Moorestown
Kowalski, Louis J., Burlington
Kuder, Joseph M., Mt. Holly
Le Favor, Dean H., Palmyra
Longsdorf, Harold E., Mt. Holly
Love, Elizabeth F., Moorestown
Lucas, W. Fred, Burlington
McDonnell, Gerald E., Mt. Holly
*Marcy, Alexander, Jr., Riverton
Mendenhall, Clinton D., Bordentown
Metzer, Emma P. W., Riverside
Meyer, Eugene A., Moorestown
Mills, Charles S., Riverton
Muldoon, Edward J., Florence
Mulford, Ephraim R. Burlington
Munro, Chas. A., Marlton
Newcomb, Mareus W., Brown's Mills
Peacock, Arthur B., Columbus
Remer, Daniel F., Mt. Holly
Rink, William, Burlington
Rodman, E. Warren, Beverly
Rogers, Harry L., Riverton
Sehisler, Milton M., Florenee
Seott, Parry M., Beverly
Shapiro, Chas. S., Maple Shade
Shipps, Hammel P., Delanco
Small, E. Lester, Medford
Stokes, Joseph, Moorestown
Stokes, Samuel Emlen, Moorestown
Summey, Thomas J., Moorestown
Thorne, Nathan, Moorestown
Traey, George T., Beverly
Ulmer, David H. B., Moorestown
Viteri, Louis, Mt. Holly
Wagner, J. G., Riverside
Wells, Willliam C., Delanco

Honorary Members

Stoddard, Francis J., Riverton

Non-Resident Associate Members

Borzell, F. F., Philadelphia, Pa.

Number of active members and basis of representation, 53.

100 per cent paid up March 1, 1935.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month October to May inclusive, with an outing in June. Annual Meeting in October.

President, Shafer, F. William, Camden

Vice-President, Lewis, Thomas K., Camden

Secretary, Gamon, Robert S., Camden

Treasurer, Shull, E. C., Camden

Reporter, Del Duca, Vincent, Camden

Historian, Bentley, David F., Jr., Camden

Censors, Davis, A. B., Camden
Day, Grafton E., Collingswood
Hummel, E. G., Camden
Lee, T. B., Camden
Van Sciver, J. E. L., Camden

Active Members

Anderson, William, 20 Kings Highw'y, W. Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
Bailey, Wilson G., 512 Broadway, Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, K. B., Kaighn & Princess avs., Camden
Barnshaw, Harold M., 2626 Federal st., Camden
*Barrett, Wesley J., 517 Cooper st., Camden
Becker, C. Fred, 620 Benson st., Camden
Beideman, Caspar M., 5 W. Maple av., Merchantv'le
Bentley, David F., Jr., 406 Cooper st., Camden
Betancourt, R. R., 406 Cooper st., Camden
Brennan, Chas. L. S., 14 S. Broadway, Gloucester
Brennan, John P., 429 Cooper st., Camden
Brewer, David R., 536 Market st., Gloucester
Brown, Stanley, Glen av., Laurel Springs
Browning, Wm. J., 134 N. Centre st., Merchantv'le
Browning, W. Kempton, 120 N. Centre st., M'ch'tv'le
Bush, Ralph K., 131 E. Park av., Merchantville
Butler, S. S., 1100 Kaighn av., Camden
Buzby, B. Franklin, 414 Cooper st., Camden
Carlander, O. R., 1972 Browning rd., Merchantville
Casselman, Arthur J., 301 N. 2nd st., Camden
Ciliberti, Frank J., 5th & Pine sts., Camden
Clark, Ernest W., 209 Haddon av., Westmont
Clement, Levina B., 124 Kings Hwy., W. H'd'nf'd
Collier, Martin H., Camden Co. Hosp., Lakeland
*Conoly, J. Holbert, 300 Monmouth st., Gloucester
Conoly, Lacy N., 601 Walnut st., Camden
Coxson, H. P., Laurel rd., Stratford
Crist, Walter A., 725 Collings av., W. Collingswood
Crowley, Joseph W., 4005 Westfield av., Camden
Davis, Albert B., 511 Cooper st., Camden
Day, Grafton E., Frazier & N. J. avs., Collingswood
Deibert, Irvin E., 618 Benson st., Camden
Del Duca, Vincent, 406 Cooper st., Camden
Denbo, Elic, 854 Haddon av., Camden
Driscoll, Chas. D., 6 White Horse Pike, Haddon H'ts
Eaton, Arthur T., 201 4th av., Haddon Heights
Ellis, Alexander, 513 Broadway, Camden
Evans, Winborne D., 2704 Westfield av., Camden
Eynon, Harold K., 579 Haddon av., Collingswood
Farrell, Edgar A., 100 Kings H'wy, W. Haddonf'ld
Favorite, Grant O., West Jersey Hosp., Camden
Filkins, Cedric E., 418 W. Horse Pike, Audubon
Fisher, Stella C., 4401 Westfield av., Camden
Gamon, Robert S., 558 Newton av., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, Geo. B., 429 Cooper st., Camden
Glover, Lawrence L., 53 King's Hwy., Haddonfield
Goldstein, Hyman I., 1425 Broadway, Camden
Hadley, C. F., 201 W. Maple av., Merchantville
Haines, Mabel S., 600 White Horse Pike, Audubon
Haines, Wm. H., 600 White Horse Pike, Audubon
Hammett, Lee J., 760 N. 27th st., Camden
Hays, Roy G., 567 Haddon av., Collingswood
Hemphill, E., 232 Kings H'wy E., Haddonfield
Hessert, Edmund C., Haddon & Col. avs., Collingsw'd
Hirst, E. Reed, 634 Federal st., Camden
Hirst, Levi B., 634 Federal st., Camden
Hollinshed, Beulah S., 600 Benson st., Camden
Horner-Roger, Clara L., 721 Cooper st., Camden
Howard, J. Edgar, 67 King's H'way, W. Hadd'nf'ld
Hughes, Thos. E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 135 N. Centre st., Merchantv'le
Hutcheson, Chas. R., 517 Cooper st., Camden
Jack, H. Wesley, 920 Haddon av., Collingswood
Jackson, Chas. H., 1250 Pk. Boulevard, Camden
Jarrett, Harry, 925 Broadway, Camden
Johnson, Chas. H., 632 Benson st., Camden
Kain, Thomas M., 403 Cooper st., Camden
Kain, Wm. W., Cape May C't House, R.F.D. No. 1
Kinney, A. G., 917 Haddon av., Collingswood
Kline, Oram R., 414 Cooper st., Camden
Kutner, Chas., 1005 S. 5th st., Camden
Larossa, Ernest A., 701 Cooper st., Camden
Leavitt, John F., 522 N. 3rd st., Camden
Lee, Thomas B., 622 Cooper st., Camden
Lewis, Thos. K., 47 S. 27th st., Camden
Lippincott, A. Haines, 406 Cooper st., Camden
Lovett, Jos. C., Municipal Hospital, Camden
Lyon, Leslie C., P. O. Box 63, Magnolia
Macalister, Alexander, 626 Federal st., Camden
MacAlpine, K. B., 308 Monmouth st., Gloucester City
McCarthy, Arthur M., 2772 Federal st., Camden
McCallum, A. S., 213 Clements Br. rd., Barrington
McConaghy, T. P., S. W. Cor. 10 & Cooper sts., C'm'n
McDermott, Vincent, 511 State st., Camden
McGlade, Thos. H., Camden Co. Hosp., Lakewood
Madden, T. W., 16 Frazier av., Collinswood
Mahaffey, Jesse L., 414 Cooper st., Camden
Maldeis, A. M. K., 117 North 6th st., Camden
Marcarian, Henry B., 904 Cooper st., Camden
Marcy, John W., 117 E. Park av., Merchantville
Mecray, Paul M., 405 Cooper st., Camden
Mengel, Willard G., 400 Penn. st., Camden
Meyer, George P., 410 Haddon av., Camden
Murray, E. N. 601 Walnut st., Camden
*Nicholson, Jos. L., 205 Washington av., Haddonfield
Ondovchak, M. F., King's Hwy., Mt. Ephraim
Ornaf, I. E., 1154 Thurman st., Camden
Osmun, Milton M., 611 Broadway, Camden
Palm, Howard F., 614 N. 2nd st., Camden
Phillips, Claude B., 891 Haddon av., Collingswood
Pike, Charles E., 411 Newton st., Oaklyn
Pinsky, Mordecia M., 944 S. 5th st., Camden
Pratt, Arthur C., 516 Cooper st., Camden
Pratt, William H., 516 Cooper st., Camden
Primas, Howard E., 772 Pine st., Camden
Principato, Roberto, 402 Walnut st., Camden
Raughley, Wm. C., Taunton av., Berlin
Read, William T., 429 Cooper st., Camden
Rhone, David S., 1202 Haddon av., Camden
Richardson, Emma M., 577 Steven st., Camden
Roberts, Jos. E., Jr., 403 Cooper st., Camden
Rogers, Edw. B., 814 Haddon av., Collingswood
Ross, Alex. S., 542 Cooper st., Camden
Rossell, Edward W., 801 Cooper st., Camden
Roth, R. F., 41 Haddon av., Westmont

Ruttenberg, Max, 303 Cooper st., Camden
Saunders, O. W., 1700 Broadway, Camden
Schall, R. E., 7th & Elm sts., Camden
Scheffler, W. A. H., 511 Cooper st., Camden
Schellenger, E. A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. 5th st., Camden
Schruggs, W. J., 3005 Kearsage rd., Fairv'w, C'md'n
Schwartz, Henry C., Atco
Shafer, Alfred H., 405 Cooper st., Camden
Shafer, Fred'k Wm., 634 Penn. av., Camden
Sharp, R. L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Sheaffer, C. P., 241 Kings Hwy. E., Haddonfield
Shemeley, Wm. C., Jr., 7 Haddon av., Camden
Sheppard, R. L., 768 N. 27th st., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, Jas. S., 542 Cooper st., Camden
Shope, E. P., 511 Cooper st., Camden
Shull, E. C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Smith, James D., 701 N. 6th st., Camden
Stein, Joseph M., 956 Newton av., Camden
Stimus, H. G., 300 Kaighn av., Camden
Stone, A. L., 2838 Berkley st., Camden
Stone, F. P., Tomlinson av., Laurel Springs
Summerill, Garnett, 330 Cooper st., Camden
Tatem, H., Pine st., Audubon
Thompson, P. H., 4612 Westfield av., Camden
Van Sciver, John E. L., 106 Broadway, Camden
Ward, Seth Allen, 325 Cooper st., Camden
Weimann, M. L., 803 Station av., Haddon Heights
West, Gordon F., 527 Penn st., Camden
Westcott, H. F., 235 Gibbsboro rd., Clementon
Wheatland, M. F., 727 Walnut st., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Wilson, I. E., 110 Chapel av., Merchantville
Wilson, L. R., 3320 Federal st., Camden
Wroblewski, B., 1166 Thurman st., Camden

Honorary Members

Leavitt, John F., Camden
Marcy, John W., 117 E. Park av., Merchantville
*Nicholson, J. L., Haddonfield

Transferred

Baker, Banks S., to Somerset County Society
Dublin, Geo. J., to Philadelphia Med. Soc.

Number of active members and basis of representation, 153.

100 per cent paid up March 1, 1935.

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Meets on first Tuesday in April and October. Annual Meeting in October.

President, Robbins, Warren D., Cape May City

Vice-President, Townsend, John B., Ocean City

Secretary, Way, Eugene, Sea Isle City

Treasurer, Tomlin, H. Hurlburt, Wildwood

Reporter, Way, Eugene, Sea Isle City

Censors, Gandy, C. M., Ocean View
Hughes, Frank R., Cape May
Ziegler, Oscar F., Wildwood

Active Members

Corson, Allen, Ocean City
Crowe, Aldrich C., Ocean City
Cryder, Millard, Cape May Court House
Dandois, George F., Wildwood
Darby, A. Eugene, Ocean City
Freeland, A. J., Woodbine
Gandy, Charles M., Ocean View
Haines, W. P., Ocean City
Hornstine, H. H., Wildwood
Hughes, Frank R., Cape May
Mace, Margaret, North Wildwood
Monasson, Ida, Woodbine
Pettit, Herschel, Ocean City
Robbins, Warren D., Cape May
Steel, William A., Beesley Point
Tomlin, H., Hurlburt, Wildwood
Townsend, John B., Ocean City
Way, Clarence W., Sea Isle City
Way, Eugene, Sea Isle City
Way, Julius, Cape May Court House
Whiticar, John H., Ocean City
Ziegler, Oscar, Wildwood

Non-Resident Honorary Members

Gandy, Charles L., U. S. A.
Gordon, Alfred, Philadelphia, Pa.
Ingram, J. H., China
Reik, Henry O., New York City

Number of active members and basis of representation, 22.

100 per cent paid up March 1, 1935.

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of January, April, July and October. Annual Meeting in October.

President, Bennett, Samuel D., Millville

Vice-President, Walker, H. Burton, Vineland

Secretary, Lyons, E. C., Bridgeton

Treasurer, Wilson, H. H., Bridgeton

Reporter, Corson, Elton S., Bridgeton

Censors, Kauffman, L. J., Millville
Gray, Charles H., Vineland
Sewall, Millard F., Bridgeton

Active Members

Bacon, Mary, Bridgeton
Baker, Hugh W., Vineland
Bellak, Ellis R., Leesburg
Bennett, Samuel D., Millville
Bostwick, Delazon S., Bridgeton
Branin, Howard S., Millville
Butcher, Charles, Heisleville
Clippinger, R. D., Vineland
Cornwell, Alfred W., Bridgeton
Corson, Elton S., Bridgeton
Cunningham, Charles, Jr., Vineland
Davies, George A., Elmer
Day, Samuel Thomas, Port Norris
Elmer, Matthew K., Bridgeton
Garrison, Walter Sherman, Cedarville
Gray, Charles M., Vineland
Harris, Allan, Greenwich
Kauffman, Louis J., Millville
Knowles, James S., Millville
Lloyd, Reba (Kump), Bridgeton
Loder, Horace B., Bridgeton
Loper, John G., Bridgeton
Lore, Harry E., Bridgeton
Lummis, C. Percy, Bridgeton
Lyon, Earl C., Bridgeton
Mayhew, Charles H., Millville
Miller, H. Garrett, Millville
Myatt, Leslie E., Bridgeton
Neal, Charles B., Millville
Oliver, David H., Bridgeton
Pino, Anthony, Bridgeton
Ramsey, F. Muriel, Millville
Reeves, J. Franklin, Bridgeton
Sewall, Millard F., Bridgeton
Sharp, Charles E., Port Norris
Sheppard, Frank R., Millville
Simpkins, Raymond, Bridgeton
Thalheimer, E. J., Vineland
Thomas, George N., Vineland
Van Deusen, Edwin H., Vineland
Wainwright, F. P., Bridgeton
Walker, Ada Harris, Vineland
Walker, H. Burton, Vineland
Ware, Carl N., Shiloh
Ware, Francis V., Millville
Weithaase, Helen E., Vineland
Whaland, Berta, Bridgeton
Wilson, Charles W., Vineland
Wilson, Herbert H., Bridgeton
Winslow, John H., Vineland
Woodruff, Dare, Vineland

Non-Resident Associate Members

Barton, J. M., 1314 Spruce st., Philadelphia, Pa.
*De Costa, J. C., 2045 Walnut st., Philadelphia, Pa.
Hirst, B. C., 1821 Spruce st., Philadelphia, Pa.
*Keen, W. W., 1729 Chestnut st., Philadelphia, Pa.
Noble, Charles P., 1509 Locust st., Philadelphia, Pa.
Reisman, David, 162 Spruce st., Philadelphia, Pa.

Number of active members and basis of representation, 51.

100 per cent paid up March 1, 1935.

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, November to May inclusive, on call of the Council. Annual Meeting is the second Thursday in October.

President, Condon, John F., Newark

First Vice-President, Zehnder, A. Chas., Newark

Second Vice-President, Ill, Edgar A., Newark

Secretary, Pinneo, Frank W., Newark

Treasurer, Rogers, Robert H., Newark

Reporter, Wood, Earl LeRoy, Newark

Councilors. Alfred Stahl 1935
David A. Kraker 1935
Walter B. Mount 1935
J. Irving Fort 1935
H. Roy Van Ness 1936
Harry N. Comando 1936
Royal A. Schaaf 1936
Herbert A. Schulte 1936
The Ex-Presidents

Active Members

Abel, Arthur R., 144 Harrison st., East Orange
Abrams, A. B., 668 Clinton av., Newark
Adams, John K., 3 Prospect st., East Orange
Adelman, Benj. B., 190 Clinton av., Newark
Agnew, Hobart M., 27 S. Fullerton av., Montclair
Albano, Joseph, 535 N. 7th st., Newark
Alexander, Wallace G., 48 Webster pl., Orange
Alford, Ralph I., 9 N. Mountain av., Montclair
Allan, James S., 49 Prospect st., East Orange
Allen, G. Herbert, 181 Roseville av., Newark
Alling, Frederick A., 15 Washington st., Newark
Altman, Charles D., 301 Highland av., Newark
Ambrose, Anthony, 71 Congress st., Newark
Angelillo, Marc C., 333 Clifton av., Newark
Antonius, N. A., 27 W. Market st., Newark
Applebaum, I. L., 394 Fairmount av., Newark
Areson, Wm. H., 153 B'vue av., Upper Montclair

Aronowitz, H., 68 Weequahic av., Newark
Asher, Maurice, 186 Clinton av., Newark
Aszody, Paul, 340 Waverly av., Newark
Avidan, Maurice S., 30 Stratford pl., Newark
Bachmann, Wm., 87 Hilcrest ter., East Orange
Bagg, Linus W., 31 Lincoln Park, Newark
Baird, T. M., 124 Grand pl., Arlington
Baker, Charles F., 198 Clinton av., Newark
Baker, Maclyn, 638 Stuyvesant av., Irvington
Baldwin, Samuel H., 626 Clinton av., Newark
Balson, Z. D. B., 884 S. 14th st., Newark
Banks, Winifred D., 6 N. Munn av., East Orange
Barkhorn, Charles W., 223 Roseville av., Newark
Barkhorn. Henry C., 45 Johnson av., Newark
Barrett, Jos. F., 230 Parker av., Maplewood
Baum. Felix, 765 S. 10th st., Newark
Baum, Samuel. 10 Osborne ter., Newark
Becker, Fred W., 14 Clinton pl., Newark
Becket, George C., 350 Springdale av., East Orange
Beling, Chris. C., 109 Clinton av., Newark
Bell, Thomas, 340 Belmont av., Newark
Benedict, A. C., 121 Irvington av., South Orange
Bengelsdorf, A., 29 Clinton pl., Newark
Bennett, W. F., Essex Co. Sanatorium, Verona
Beradinelli, C. G., 92 Eighth av., Newark
Berg, S., 156 Roseville av., Newark
Berger, W. A., 346 Roseville av., Newark
Bergman, M. W., 825 S. 10th st., Newark
Berman, H. Robert, 286 Roseville av., Newark
Beyer, O. J., 42 Laurel av., Irvington
Bianchi, Angelo R., 520 Sanford av., Newark
Bien, Frank A., 999 Clinton av., Irvington
Bigelow, N. S., 117 Irvington av., South Orange
Bingham, Arthur W., 144 Harrison st., East Orange
Birdsall, Clarence, 3 Small av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 25 S. Munn av., East Orange
Bleick, Theo. E., 61 Van Ness pl., Newark
Bleick, William D., 583 Prospect av., Maplewood
Bleier, Louis, 88 Clinton av., Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Bonomo. Michael J., 477 Springfield av., Newark
Bostwick, Wallace R., 56 Church st., Montclair
Bove, Joseph, 306 Lincoln av., Orange
Brackett, Elizabeth R., 349 Franklin av., Nutley
Bradford, Stella S., 16 Seymour av., Montclair
Bradshaw, John H., 27 High st., Orange
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Braun, Gus A., 391 Bergen st., Newark
Breitstadt, Chas. A., 168 Dalevan av., Newark
Brien. Wm. M., 449 Main st., Orange
Briggs, H., 16 Undercliff ter., West Orange
Brin, Anne J. S., 83 Lincoln Park, Newark
Broadnax, Mary E., 83 Lincoln Park, Newark
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, H. A., 365 Osborne ter., Newark
Brooke, Chas. R., 13 Pennington st., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown. Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown, E. V., 585 Kearny av., Arlington
Brown, Lewis W., 15 Fulton st., Newark
Brown, Richard J., 105 Ridgewood rd., South Orange
Buckley, J. L., 666 Franklin av., Nutley
Bull, Louis M., 92 Heller Parkway, Newark
Bull, Robert I., 531 W. Market st., Newark
Bull, W. J., 98 Park st., Montclair
*Bumsted, Clarence, 235 Grafton av., Newark
Bunn, Frank C., 30 Hillyer st., Orange
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burns, Edward L., 269 Broad st., Newark
Burpeau, Wm. P., 144 Harrison st., East Orange
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union av., Montclair
Butler, Eustace C., 249 Bloomfield av., Caldwell
Buvinger, Chas. W., 50 Washington st., E. Orange
Cacciarelli, Robt. A., 517 Roseville av., Newark
Cahill, L. A., 353 Lafayette st., Newark
Caldwell, J. A., 45 S. Mountain av., Montclair
Calvert, Wm. C., 220 Central av.. Orange
Camche, L. J., 250 Renner av., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, H. B., 21 Court st., Newark
Campbell, Wm., 144 Harrison st., East Orange
Carbone, Francis R., 157 Hunterdon st., Newark
Cardwell, E. P., 47 Central av., Newark
Carman, Fletcher F., 31 Lincoln Park, Newark
Carrigan, Francis P., 288 Franklin av., Nutley
Caruso, Rocco J., 222 Mt. Prospect av., Newark
Casale, John B., 496 Highland av., Newark
Cater, Douglas A., 55 Harrison st., East Orange
Cerone, Daniel M., 398 N. 11th st., Newark
Chamberlain, Aims R., 30 Lenox pl., Maplewood
Chapman, R. W., 835 Bergen st., Newark
Chenitz, Wm., 530 Orange st., Newark
Chereshore, Henry, 363 Center st., Nutley
Cheskin, Louis T., 115 Mapes av., Newark
Chisholm, Gibbs, 14 Boston st., Newark
Chmelnik, A. G., 299 Clinton av., Newark
Clark, J. Henry, 108 Orange rd., Montclair
Clarken, Jos. A., 43 Lincoln Park, Newark
Coburn, John W., 111 No. Parkway, E. Orange
Coe, Richard, 156 Clinton av., Newark
Coffin, Henry, 433 Mt. Prospect av., Newark
Coghlan, Jasper, 17 Academy st., Newark
Cohen, I. E., 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Meyer J., 32 Runyon st., Newark
Cohen, Sidney L., 20 Avon av., Newark
Cohn, G. M., 748 S. 10th st., Newark
Cohn, Herman, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Comando, Harry N., 690 Clinton av., Newark
Condon, John F., 686 Mt. Prospect av., Newark
Conlon, Philip, 25 James st., Newark
Connamacher, H. S., 671 Springfield av., Newark
Connolly, John J., 212 Market st., Newark
Connolly, Richard N., City Hospital, Newark
Cook, H. F., 31 Lincoln Park, Newark
Cooke, Wm. H., 303 Main st., East Orange
Cooperman, Wm., 647 Market st., Newark
Corwin, Theo. W., 671 Broad st., Newark
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 24 Beech st., Arlington
Cox, John Calvin, 55 Woodland rd., Maplewood
Cox, William W., 27 S. Fullerton av., Montclair
Crane, Chas. G., 78 Farley av., Newark
Crankshaw, Chas. W., Prudential Bldg., Newark
Craster, Chas. V., 381 Parker st., Newark
Crawford, Georgiana U., 28 Carnegie av., E. Orange
Crecca, Wm. D., 111 Park av., Newark
Crossfield, H. C., 491 S. Orange av., South Orange
Crystell, E. H., Hillside av., Nutley
Curtis, Elbert A., 65 Central av., Newark
D'Acunto, P., 141 Mt. Prospect av., Newark
Dane, Chas., 61 Scotland rd., South Orange
Dane, John, 61 Scotland rd., South Orange
Danzis, Max, 31 Lincoln Park, Newark
Darden, Walter T., 149 W. Kinney st., Newark
Davenport, Peter B., 764 S. Orange av., Newark
Davidson, Henry A., 31 Lincoln Park, Newark
Davidson, Louis L., 31 Lincoln Park, Newark
Davies, Geo. W., 15 Fairview av., Verona
Davis. Louis, 825 S. 10th st., Newark
DeFronzo, Morando, 180 Fairmount av., Newark
Deignan, Wm. L., 257 Dodd st., East Orange
Del Deo, Nicholas V., 47½ State st., Newark
Del Guercio, O., 342 Clifton av., Newark

Demarest, L. M., 228 S. Orange av., South Orange
Denes, O. J., 402 Centre av., Nutley
Deriveaux, John A., 103 Clinton av., Newark
Deutel, Oscar R., 283 Franklin st., Bloomfield
De Vausney, Winfield S., 50 James st., Newark
De Vincentis, Henry, 285 Henry st., Orange
Devlin, Frank, 617 Broadway, Newark
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Rich'd H., 570 Mt. Prosp't av., Newark
Dinge, Ferdinand Chas., 67 S. Munn av., E. Orange
Dodd, Edward L., 151 Forest st., Belleville
Donahue, Wm. J., 173 Roseville av., Newark
Donnelly, Robt. J., 208 Market st., Newark
Doremus, Widmer E., 375 Mt. Prospect av., Newark
Dorn, Elliot I., 267 Vassar av., Newark
Dowd, Ambrose F., 239 Broadway, Newark
Dragonetti, E. N., 177 Clifton av., Newark
Dranow, Paul, 205 Franklin av., Nutley
Dreskin, J. L., 172 Lyons av., Newark
DuBois, M. G., 769 High st., Newark
Dulin, Everett K., 144 Harrison st., East Orange
Dunn, Theodore B., 194 Broad st., Bloomfield
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, S. W., 344 High st., Newark
Echikson, Joseph I., 845 S. 12th st., Newark
Edelen, James J., 280 S. Clinton st., East Orange
Eigen, Louis A., 358 Gregory av., West Orange
Ein, Wm. B., 31 Lincoln Park, Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Ellis, Moury I., 177 S. Clinton st., East Orange
Emerson, Linn, 310 Main st., Orange
Emmer, S. Wolfe, 234 Clinton av., Newark
English, James R., 51 Cypress st., Newark
English, John T., 681 Stuyvesant av., Irvington
Epler, Don A., 45 Hillside ave., Newark
Epstein, Henry B., 31 Lincoln Park, Newark
Erler, Eugene W., 119 N. 5th st., Newark
Ervin, Millard B., 572 Prospect st., Maplewood
Etheridge, Charles E., 479 Prospect st., East Orange
Evans, Charles H., 144 Harrison st., East Orange
Ewing, Harvey M., 31 Lincoln Park, Newark
Fager, Rudolph O., 98 Broad st., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol. J., 31 Lincoln Park, Newark
Farden, Jos. L., 342 Roseville av., Newark
Farr, Irving L., 214 Walnut st., Montclair
Fasano, G., 194 S. 7th st., Newark
Faughnan, Rose, 97 High st., Passaic
Fechner, Julius, 138 W. Kinney st., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Fendrick, Edward, 91 Watson av., East Orange
Feneck, Chas. C., 510 Roma av., Phoenix, Ariz.
Ferguson, W. E., 1175 Raymond B'vd., Newark
Fern, S. S., 122 Elizabeth av., Newark
Fewsmith, Jos. L., 120 Second av., Newark
Fine, Moses J., 175 Clinton av., Newark
Finesilver, Edward M., 31 Lincoln Park, Newark
Finkel, Joshua, 368 Clinton av., Newark
Finkelstein, A. S., 670 Clinton av., Newark
Finkler, Rita S., 35 Leslie st., Newark
Fischman, H. H., 34 Sterling st., Newark
Fitzpatrick, Edward F., 574 Warren st., Newark
Flower, M. A., 39 Lincoln Park, Newark
Flynn, E. A., 161 Washington av., Belleville
Forsythe, Kenneth C., 530 Summer av., Newark
Fort, J. Irving, 306 Roseville av., Newark
Forte, Frank S., 456 Roseville av., Newark
Foster, Herbert W., 2 Erwin Park, Montclair
Foster, W. S., 233 Mt. Prospect av., Newark
Fowler, Royal H., 744 Broad st., Newark
Fredericks, Gus H., 349 Camden st., Newark
Freeman, George C., 1 Lenox pl., Maplewood
Freeman, Richard D., 103 Scotland rd., S. Orange
Freinkel, Jacob, 2 Hillside av., Newark
Friedman, Harry, 721 S. 16th st., Newark
Friedman, Hyman, 1096 Sanford av., Irvington
Froelich, J. C., 74 Ingraham pl., Newark
Froomess, Leo H., 775 High st., Newark
Fuerstman, H. L., 570 High st., Newark
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 190 Johnson av., Newark
Ganley, Arthur J., 390 Park av., East Orange
Ganot, F. I., 639 Ridge st., Newark
Gardam, J. W., 16 Longfellow av., Newark
Gauch, Wm., 177 Ellwood av., Newark
Gelber, L. J., 41 Lincoln Park, Newark
Gennell, Ernest, 298 Parker st., Newark
George, M. E. W., 805 Broadway, Newark
Gershenfeld, David B., 20 Hillside av., Newark
Gifford, W. Royal, 247 Park av., East Orange
Gilman, Malcolm B., 59 Seely av., Arlington
Glass, Oscar, 838 S. 12th st., Newark
Glass, William H., 144 Harrison st., East Orange
Godfrey, Allan O., 220 Roseville av., Newark
Goeller, J. D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 81 Valley rd., Montclair
Goldberg, H. H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 46 Farley av., Newark
Goldberg, Samuel M., 353 Wash av., Belleville
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, W. H., 632 Belgrove dr., Arlington
Goodfellow, G. P. 526 Park av., East Orange
*Goodwin, Wm. M., 75 Congress st., Newark
Gordon, A. J., 273 Roseville av., Newark
Grady, Wm. F., 42 N. Fullerton av., Montclair
Graham, Richard B., 90 Midland av., Arlington
Grant, William F., 162 Roseville av., Newark
Gray, John W., 142 Clinton av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, B. H., 691 Clinton av., Newark
Gregorius, Ralph F., 120 Irvington av., S. Orange
Gregory, Mildred G., 21 Roseville av., Newark
Greifinger, Marcus H., 22 Vassar av., Newark
Griffith, Roy, 909 Broad st., Newark
Grossblatt, Philip, 70 Baldwin av., Newark
Guthrie, W. G., 300 Summer av., Newark
Gutowski, W. T., 104 Grove ter., Irvington
Hagerty, John F., 212 W. Market st., Newark
Hagney, Fred W., 669 Elizabeth av., Newark
Hahn, Katherine B., 272 Thornden st., South Orange
Hahn, William, 272 Thornden st., South Orange
Halprin, Harry, 8 Washburn pl., Caldwell
Halsey, Levi W., 61 Church st., Montclair
Hanan, Jas. T., 11 The Crescent, Montclair
Harden, Albert S., 540 Warren st., Newark
Harhen, Geo. E., 22 Brookside av., Caldwell
Harvey, Thos. W., 59 Main st., Orange
Harvey, Thos. W., Jr., 59 Main st., Orange
Haskell, I. D., 387 Fairmount av., Newark
Hasney, Frederick A., 292 Main st., West Orange
Hauck, Lydia B., 644 Stuyvesant av., Irvington
Hauck, Wm. H., 644 Stuyvesant av., Irvington
Haussling, Francis R., 661 High st., Newark
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Zeh, 84 Washington st., Newark
Heath, Louanna, 20 Fairmount av., Newark
Heineken, T. S., 17 Park pl., Bloomfield
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, C. B., 671 Springfield av., Newark
Herman, John H., 197 S. Centre st., Orange
Herold, H. C. H., 1115 Broad st., Newark
Herold, Harvey T., 850 S. 13th st., Newark
Hersh, David H., 658 Springfield av., Newark
Hewson, James S., 163 Myrtle av., Millburn
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Hicks, William H., 46 Milford av., Newark
Hill, Robert H., 332 Park av., Newark
Hilton, C. O., 598 N. 5th st., Newark
Hobart, Richard T., 191 Belleville av., U. Montclair

Holden, Edgar, Jr., 217 Broadway, Newark
Holland, Geo. A., 364 Clinton av., Newark
Holler, Henry G., 234 Montclair av., Newark
Holmes, Geo. J., 17 Elizabeth av., Newark
Hood, Philip G., 19 Lincoln Park, Newark
Horn, Max, 94 Lyons av., Newark
Horsford, Fred C., 305 Broadway, Newark
Hosp, Paul H., 842 S. 12th st., Newark
Houck, W. J., 207 Mt. Prospect av., Newark
Hubbard, Fayette E., 65 Church st., Montclair
Hubbard, Robert Y., 58 Myrtle av., Irvington
Huber, Wm. H., 15 Salem st., Newark
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., E. Orange
Humphries, Robert E., 637 Central av., East Orange
Hurff, Jos. W., 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Charles L., 188 Clinton av., Newark
Ill, Edgar A., 1002 Broad st., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Irwin, Jas. R., 330 Washington av., Belleville
Jackson, Albert F., 225 Hillside av., Nutley
Jackson, E. C., 98 Washington st., East Orange
James, Bart M., 31 Lincoln Park, Newark
James, Wm. L., 31 Lincoln Park, Newark
Janifer, Clarence S., 208 Parker st., Newark
Jaso, James V., 274 Littleton av., Newark
Jedel, Meyer, 125 Fourth st., Newark
Jessurun, S. H., 613 High st., Newark
Jonitz, Robert, 157 S. Grove st., East Orange
Judge, John F., 1009 S. Orange av., Newark
Just, Francis, 564 High st., Newark
Kahrs, Grace M., 375 Mt. Prospect av., Newark
Kaufhold, Frank, 41 Leslie st., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, M. J., 103 Lyons av., Newark
Kavanaugh, D. E., 252 Washington av., Belleville
Kearney, Edward P., 26 Forest st., Montclair
Keim, Wm. F., 25 Roseville av., Newark
Keller, Sidney C., 31 Lincoln Park, Newark
Kennedy, Wm. M., Essex Co. Sanatorium, Verona
Kenney, J. A., 132 W. Kinney st., Newark
Kern, E. Clarence, 45 Park st., Montclair
Kerns, Francis J., 556 Warren st., Newark
Kessell, J. S., 643 Central av., East Orange
Kessler, H. H., 31 Lincoln Park, Newark
Kessler, Henry B., 666 Clinton av., Newark
Kirkby, Cyril S., 98 Broad st., Bloomfield
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Edward C., Jr., 209 Littleton av., Newark
Klenk, J. P., 328 Belleville av., Bloomfield
Kolodin, A., 147 Franklin st., Bloomfield
Kraemer, Manfred, 186 Clinton av., Newark
Kraker, David A., 31 Lincoln Park, Newark
Krone, W. F., 31 Lincoln Park, Newark
Kruger, William, 31 Lincoln Park, Newark
Kummel, M., 31 Lincoln Park, Newark
Lafferty, Elton B., 328 Myrtle av., Irvington
Lane, Austin W., 98 Prospect st., East Orange
Lane, Frank B., 53 Woodland av., East Orange
LeBel, Louis J. B., 165 Grant av., Nutley
Lee, Stephen G., 55 Halsted st., East Orange
Lehman, Irving J., 558 Central av., Newark
Leonardis, Jas. V., 94 Jefferson st., Newark
Levin, M. L., 326 Avon av., Newark
Levinson, L. J., 18 Stratford pl., Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Julius, 66 Baldwin av., Newark
Lewis, Geo. R., 458 Washington av., Belleville
Leyenberger, S. B., 319 Mt. Prospect av., Newark
Lipphard, Alvin T., 682 Stuyvesant av., Irvington
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis Henry, 31 Lincoln Park, Newark
Long, Herbert W., 102 Jefferson st., Newark
Lottridge, Dorothy, 43 S. Maple av., East Orange
Lovell, Frederick H., 1013 Clinton av., Irvington
Lovell, John F., 1011 Clinton av., Irvington
Lowenstein, H. A., 96 Milford av., Newark
Lowrey, Jas. H., 79 Congress st., Newark
Lowy, Otto, 190 Clinton av., Newark
Luban, Benjamin, 730 High st., Newark
Lundblad, Walt. E., 75 Prospect st., East Orange
Lurie, Sol I., 21 Hillside av., Newark
Lynch, A. E. O., 257 Orange rd., Montclair
Lyon, Archibald, 115 Ridge rd., Arlington
Lyons, James V., 333 Park av., Orange
MacArthur, Clymont, 219 Roseville av., Newark
Macdonald, W. S., 56 Church st., Montclair
MacPherson, Elwood H., 12 Rawley pl., Millburn
McBride, Hesser G., 1072 S. Orange av., Newark
McCabe, Thos. S., 913 Broad st., Newark
McCauley, Francis J., 31 Lincoln Park, Newark
McCormick, Jas. E., 322 Clinton av., Newark
McCroskery, Jas. H., 396 N. Arlington av., E. Or.
McEwen, Floy, 299 Broadway, Newark
McKim, William F., 1044 S. Orange av., Newark
McLellan, Geo. A., 19 Hawthorne av., East Orange
McVay, Edward A., 234 Lafayette st., Newark
Maas, Max A., 329 Clinton av., Newark
Mabey, J. Corwin, 242 Claremont av., Montclair
Maggio, Geo. A., 110 Fleming av., Newark
Magovern, Thomas, 226 S. Orange av., South Orange
Mahood, H. L., 86 Durand rd., Maplewood
Malavazos, Antonio, 635 High st., Newark
Maliniak, Jacques W., 1125 Park av., New York C'y
Mamlet, Alfred M., 16 Johnson av., Newark
Mancusi-Ungaro, E., 270 Mt. Prospect av., Newark
Mancusi-Ungaro, L., 156 Mt. Prospect av., Newark
Marcus, Alexander, 55 Oxford st., Newark
Marks, Edward G., 655 Kearny av., Arlington
Marquis, Dean W., 144 Harrison st., East Orange
Marquis, W. James, 198 Clinton av., Newark
Martin, Wm. P., 25 Holland rd., South Orange
Martinetti, Carlo D., 311 Central av., Orange
Martland, Harrison S., 180 Clinton av., Newark
Matheke, O. G., 328 Sussex av., Newark
Matheson, G. E., 649 Central av., East Orange
Matthews, H. E., 504 Hillside av., Orange
Matthews, W. F., 11 Seymour av., Montclair
May, Ernst A., 965 Broad st., Newark
Medd, John C., 25 Curtis pl., Maplewood
Meehan, Martin M., 201 Joralemon st., Belleville
Meeker, Frank B., 355 Clifton av., Newark
Meeker, Irving A., 581 Valley rd., Upper Montclair
Mellen, S. H., 863 Mt. Prospect av., Newark
Menk, Paul E., 31 Lincoln Park, Newark
Merliss, Eugene, 386 Clinton av., Newark
Merselis, John G., 110 Irvington av., South Orange
Meurlin, Alfred, 158 Harrison st., East Orange
Mick, Edwin C., 54 Main st., Orange
Miller, Jos. A., 364 Prospect st., South Orange
Minard, E. L., 140 4th av., East Orange
Minier, Carl L., 15 Fulton st., Newark
Minnefor, C. A., 126 Carolina av., Newark
Minningham, Wm. D., 18 Hedden ter., Newark
Mintz, Abraham, 108 Treacy av., Newark
Mishell, Daniel R., 730 Prospect st., Maplewood
Mitchell, August J., 59 South st., Newark
Mockridge, Oscar A., 8 S. Mountain av., Montclair
Moeckel, Clarence W., 34 Plymouth st., Montclair
Mohrbacher, J. J., 37 Osborne ter., Newark
Moore, John D., 6 Washington av., Bloomfield
Morgan, Browne, 260 Liberty st., Bloomfield
Morris, Clement, 513 Broadway, Newark
Morrison, Caldwell, 379 7th av., Newark

Morrison, J. Bennett, 66 Milford av., Newark
Moschkowitz, Herman, 739 High st., Newark
Motzenbecker, P. F., 680 High st., Newark
Motzenbecker, Wm., 16 Milford av., Newark
Moulton, Chas. D., 122 Park av., East Orange
Mount, Walter B., 21 Plymouth st., Montclair
Mullin, Raymond J., 857 S. 11th st., Newark
Murray, Harold A., 624 Mt. Prospect av., Newark
Muta, Samuel A., 47 Park av., West Orange
Nappi, P. E., 215 Mt. Prospect av., Newark
*Nash, Albert B., 10 South 13th st., Newark
Nash, Alexander E., 20 Forest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nash, Wm. G., 20 Clinton st., Newark
Nataro, Joseph. 172 Littleton av., Newark
Neare, Clifford B., 2 Hawthorne av., East Orange
Nemzek, Wm. P. B., 141 Ridge rd., Arlington
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 10 Osborne ter., Newark
Noll, Louis, 1044 Clinton av., Irvington
Nyiri. William, 30 Van Ness pl., Newark
O'Connor, D. F., 671 Broad st., Newark
O'Connor, M. J., 98 Shanley av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
Olcott, Geo. P., 144 Harrison st., East Orange
Oleynick, S., 107 Clinton av., Newark
Olini, Joseph J., 30 W. Market st., Newark
O'Neil, Chas. L., 11 N. 7th st., Newark
Opdyke, C. P., 10 Summit rd., Verona
Opdyke, Gordon McC., 10 Summit rd., Verona
Openchowski, M., 52 Jones st., Newark
Orloff, Samuel, 97 Lyons av., Newark
Orton, Henry B., 24 Commerce st., Newark
Osborn, John H., 111 N. Parkway, E. Orange
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 28 Winans st., East Orange
Palmer, H. S., 257 Mulberry st., Newark
Panitch, Wm., 352 Belmont av., Newark
Pannell, Walter L., 7 Prospect st., East Orange
Pannullo, John N., 266 Van Buren st., Newark
Parent, Sol., 924 S. 20th st., Newark
Parisi, Anthony, 150 Hunterdon st., Newark
Parker, John E., 385 Park av., Orange
Parsonnet, Eugene V., 31 Lincoln Park, Newark
Paul, G. A., 765 Lyons av., Irvington
Pavia, John R., 365 Chancellor av., Newark
Payne, Guy, Overbrook Hospital, Cedar Grove
Peer, Lyndon A., 965 Broad st., Newark
Pendexter, S. E., 11 S. Arlington av., E. Orange
Pennington, A. W., 182 Roseville av., Newark
Perham, Bertram S., 199 Lorraine av., Up. Montcl'r
Petry, William, 109 Treacy av., Newark
Philhower, Geo. B., 281 Grant av., Nutley
Phillips, A. A., 68 West Market st., Newark
Pilch, Arthur G., 1 Willard av., Bloomfield
Pinneo, Frank W., 439 Mt. Prospect av., Newark
Pizzi, Francis W., 205 Park av., Orange
Plain, Irving H., 2 Stratford pl., Newark
Plant, J. S., 467 High st., Newark
Plante, Amos A., 228 Dunnell rd., Maplewood
Polevski, J., 682 High st., Newark
Pollis, Nicholas, 562 High st., Newark
Polow, Benjamin, 318 Hawthorne av., Newark
Pomeranz, R., 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Preston, Perry B., 12 Palm st. ,Newark
Price, Nathaniel G., 31 Lincoln Park, Newark
Pringle, F. A., 192 Claremont av., Montclair
Pudney, W. R., 11 Seymour st., Montclair
Quinby, Wm. O' Gorman, 14 James st., Newark
Rado, William, 190 Clinton av., Newark
Rados, Andrew, 299 Clinton av., Newark
Ramos, Nicholas J., 188 Market st., Newark
Randall, Chas. H., 50 3rd av., Newark
Ranson, Bris. B. J., 601 Ridgewood av., Maplewood
Rathgeber, Chas. F., 18 William st., East Orange
Rathgeber, Wm. M., 249 Roseville av., Newark
Ravitz, S. F., 1143 Broad st., Newark
Rawitz, Sidney B., 42 Chancellor av., Newark
Reich, A. L., 83 Lyons av., Newark
Reich, Henry, 31 Lincoln Park, Newark
Reilly, C. J., 321 S. 9th st., Newark
Reilly, John V., 472 Sanford av., Newark
Reissman, E., 31 Lincoln Park, Newark
Reitter, G. S., 144 Harrison st., East Orange
Renzuli, Francesco, 228 S. 7th st., Newark
RePass, Paul E., 144 Harrison st., East Orange
Rettig, I. L., 36 Milford av., Newark.
Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Harry H., 32 Broad st., Newark
Richardson, Arthur, 60 Orange rd., Montclair
Ricketts, Henry E., 31 Lincoln Park, Newark
Riggins, Edwin N., 161 No. Arlington av., E. Orange
Rizzolo, Edward M., 250 Mt. Prospect av., Newark
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 909 Broad st., Newark
Roberts, A. H., 24 S. 9th st., Newark
Roberts, D. C., 1536 N. Broad st., New Or'ns, Fla.
Roberts, Frank A., Budd Lake
Roberts, W. A., 9 Forest av., Caldwell
Robie, T. R., 144 Harrison st., East Orange
Rocco, Frank, 729 Summer av., Newark
Roeber, Wm. J., 21 Nesbit ter., Irvington
Rogers, Harry, 144 Harrison st., East Orange
Rogers, Richard M., 1 Wallace st., Newark
Rogers, Robert H., 49 9th av., Newark
Roh, Robert F., 671 Broad st., Newark
Rose, Mary D., 453 Park av., Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenstein, S. L., 557 Clinton av., Newark
Roth, Oswald H., 210 Littleton av., Newark
Roth, S. R., 31 Lincoln Park, Newark
Rothenberg, Samuel, 132 Osborne ter., Newark
Rothhouse, Burnet, 19 Lincoln Park, Newark
Rothseid, Abraham, 29 Scheerer av., Newark
Rothstein, I. B., 16 Lyons av., Newark
Rubinow, Saul M., 755 High st., Newark
Rumage, Wm. T., 573 Sanford av., Newark
Runyan, Wm. J., 106 Broad st., Bloomfield
Russell, L. C., 192 Clinton av., Newark
Russomano, R. L., 101 Clifton av., Newark
Saslow, Benj., 680 Clinton av., Newark
Satchwell, H. H., 640 Stuyvesant av., Irvington
Sax, Max T., 84 Grove st., Irvington
Sbarra, F., 531 W. Market st., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaefer, Eugene P., 12 Harrison pl., Irvington
Schaffer, Nathan, 172 S. Arlington av., East Orange
Schectman, Vera, 385 Osborne ter., Newark
Scher, Maurice A., 137 Lyons av., Newark
Schiller, Nicholas, 9 Pierce st., Newark
Schimmelpfennig, R. D., 258 Clarem'nt av., M'tchair
Schmukler, Jacob, 29 Rutgers st., Maplewood
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schramm, Joseph A., 23 Darcy st., Newark
Schreck, Harry, 139 Roseville av., Newark
Schulsinger, S., 48 Walnut st., Newark
Schulte, H. A., 701 Clinton av., Newark
Schults, Anna R., 207 Summer av., Newark
Scott, R. Hunter, 205 Roseville av., Newark
Scranton, Chas. W., 59 Washington st., E. Orange
Scudder, F. D., 63 S. Fullerton av., Montclair
Seidler, V. B., 16 Plymouth st., Montclair
Seidler, William F., 29 Rossmore pl., Belleville
Seidman, E. A., 580 High st., Newark
Seidman, Marcus, 580 High st., Newark
Seifert, Edwin A., 247 Claremont av., Montclair
Sellers, Robert R., 19 Chestnut st., Newark
Shannon, James B., 56 Church st., Montclair

Shannon, Lardner M., 66 S. Fullerton st., Montclair
Shapiro, Louis, 146 Broad st., Newark
Shaul, F. G., 10 Washington st., Bloomfield
Sheehan, Daniel C., 773 Sanford av., Newark
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 131 Renner av., Newark
Siegel, J. W., 96 S. 10th st., Newark
Silverstein, Benj. J., 32 Hillside av., Newark
Silverstein, J. M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, Geo. F., 541 Page st., Lyndhurst
Simon, Ludwig L., 201 Ferry st., Newark
Simonson, Louis, 202 Osborne ter., Newark
Singer, Max,. 147 Johnson av., Newark
Skwirsky, Joseph, 170 Hawthorne av., Newark
Slupas, Aldona, 369 Belmont av., Newark
Smalley, Sara D., 530 Clifton av., Newark
Smalzried, E. W., 167 N. Grove st., East Orange
Smith, Byron J., 851 S. Orange av., East Orange
Smith, E. L., Soho Hospital, Belleville
Smith, G. H., 136 Evergreen pl., East Orange
Smith, H. G., Cedar Grove
Smith, Harold W., 179 Clinton av., Orange
Smith, J. J., 325 13th av., Newark
Smith, L. H., 32 Washington st., East Orange
Smith, T. A., Short Hills
Snavely, Earl H., City Hospital, Newark
Sobin, Julius, 24 Waverly av., Newark
Somers, Fred L., 144 Harrison st., East Orange
Spallone, Jos. C., 123 Mt. Prospect av., Newark
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 34 Lyons av., Newark
Stahl, Alfred, 55 Lincoln Park, Newark
Stahl, Charles, 659 Sanford av., Newark
Steiner, Edwin, 19 Lincoln Park, Newark
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stoddard, Gordon V., 41 S. Munn av., East Orange
Stokes, Earl B., 144 Harrison st., East Orange
Straub, Herbert H., 242 Springdale av., East Orange
Sutton, Jos. G., Essex County Hosp., Cedar Grove
Symes, Earl H., 161 Kearny av., Kearny
Synnott, Martin J., 63 Fullerton av., Montclair
Szerlip, L., 31 Lincoln Park, Newark
Talbot, Herbert S., 144 Harrison st., East Orange
Tarbell, Harold, 11 Pennington st., Newark
Taylor, Herbert G., 590 Ridge av., Maplewood
Teeter, Charles E., 418 Orange st., Newark
Teimer, Theodore, 17 Hillside av., Newark
Tenney, Albert S., 164 Harrison st., East Orange
Terriberry,W.K.,Med.Dept.St.Oil Co.N.J.,26 B'y,N.Y.C.
Thomas, J. H., Jr., 270 Lenox av., South Orange
Thomas, Ruth B., 1 Park pl., Bloomfield
Thomas, Wm. B. S., 1 Park pl., Bloomfield
Thompson, Arthur F., 157 Harrison st., East Orange
Thompson, Austin B., 479 Highland av., Orange
Thompson, C. S., Fair Oaks Sanatorium, Summit
•Tildon, John W., 54 N. Clinton st., East Orange
Tirrell, C. M., 725 High st., Newark
Tobey, F. J., 11 Hazelwood av., Newark
Tomassi, Chas. F., 173 Lafayette st., Newark
Tomec, Richard F., 55 S. Park st., Montclair
Toye, John E., 590 Kearny av., Arlington
•Trainor, James H., 40 Johnson av., Newark
Turi, A., 57 Garside st., Newark
Turner, C. F., Grove & Cambr. sts., Montclair
Tushnet, Leonard, 668 18th av., Irvington
Tutchulte, E., 111 Mt. Pleasant av., Newark
Twitchell, A. B., 162 S. Orange av., South Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 170 Fleming av., Newark
Vail, Herbert B., 301 Washington av., Belleville
Vanderhoff, Irving M., 9 Clinton st., Newark
Van Der Veer, H. G., 295 Montgomery st., Bl'mfield
Van Duzer, Reeves B., 226 N. Park st., East Orange
Van Emburg, Geo. H., 575 Belgrove dr., Arlington
Van Geison, Edward J., 17 Park pl., Bloomfield
Vannatta, Geo. W., 224 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, George B., 26 Washburn pl., Caldwell
VonHofe, Fred'k H., 255 Conway ct., East Orange
Voorhees, Florence E., 83 Lincoln Park, Newark
Vreeland, Ralph D., 130 Woodland av., East Orange
Wakeley, W. E., 521 Main st., East Orange
Wallhauser, Henry J. F., 31 Lincoln Park, Newark
Walton, R. W., 48 N. Fullerton av., Montclair
Wambaganss, M., 44 Devine st., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, Wm. R., 112 Chancellor av., Newark
Warner, Wm. H. A., 444 Central av., East Orange
Weber, Francis C., 286 Mt. Prospect av., Newark
Webner, C. Fred., 71 Lincoln Park, Newark
Weinberg, Maurice M., 377 Osborne ter., Newark
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Morris, 643 Chancellor av., Irvington
Weinstock, Michael P., 13 Hillside av., Newark
Weiss, Louis, 849 S. 11th st., Newark
Weiss, Selma, 2 Stratford pl., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wheeler, W. K., 31 Lincoln Park, Newark
Wherry, Elmer G., 323 Clinton av., Newark
White, Robert R., 25 S. Munn av., East Orange
Wilkes, Arthur C., 36 Osborne ter., Newark
Willan, E. H., 238 Elmwynd dr., Orange
Willey, F. Parker, 5 Park st., Bloomfield
Williams, J. J., 88 Walnut st., Newark
Willner, Irving, 18 Waverly av., Newark
Willson, James H., 144 Harrison st., East Orange
Wintsch, Carl H., 841 S. 12th st., Newark
Wolfe, James C., 56 Church st., Montclair
Wolfe, J. S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 192 Roseville av., Newark
Woolf, Bernard H., 15 Hedden ter., Newark
Wort, Frederick J., Jr., 1080 Broad st., Newark
Wrensch, Alex. E., 79 Valley rd., Montclair
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 1 Park pl., Bloomfield
Yaguda, Asher, 88 Clinton av., Newark
Ylvisaker, L. S., Prudential Ins. Co., Newark
Young, I. H., 1203 Clinton av., Irvington
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmerman, R., 1 Baldwin av., Newark
Zweibel, Leonard, 29 Girard pl., Newark
Zweigel, I., 92 Sunnyside ter., East Orange

Associate Members

Aikman, E. M., 30 Oak lane, Essex Fells
Albano, Enrico H., 242 Clifton av., Newark
Allen, Raymond N., 144 Harrison st., East Orange
Bauman, Everett O., 30 Wilbur av., Newark
Beling, C. Abbott, 111 Clinton av., Newark
Blinn, Arthur R., 100 Chestnut st., East Orange
Block, Milton, 1472 W. Clinton av., Irvington
Bocchini, Jos., 336 S. 12th st., Newark
Borsher, Irving P., 255 Broad st., Bloomfield
Caggiano, A. P., 136 Grove st., Montclair
Caputo, Anthony R., 15 DeWitt av., Belleville
Carroll, Wilfred, 56 Goodwin av., Newark
Cetrulo, G. I., 218 Mt. Prospect av., Newark
Chimacoff, H., 171 Elizabeth av., Newark
Claus, C. H., 239 21st st., Irvington
Clayton, James O., 516 Broad st., Newark
Clement, B. L., 31 Lincoln Park, Newark
Cohn, Adele B., 89 Farley av., Newark
Cohen, Max, 732 Lyons av., Newark
Cohen, Sidney Peck, 188 High st., Nutley
Colton, Ethan T., Jr., 220 Park st., Montclair
Davis, Thomas C., 16 Old Short Hills rd., Millburn

DeFino, F. J., 463 N. 7th st., Newark
DiGiacomo, Wm. H., 2 Prospect pl., Newark
Flanagan, John J., 15 Fulton st., Newark
Fortunato, Jos. F., 224 Van Buren st., Newark
Fost, William H., 107 Franklin st., Belleville
Geller, Samuel, 784 High st., Newark
Greenfield, L. S., 691 Clinton av., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Haley, Paul W., 229 Smith st., Newark
Hantman, Harold, 530 Orange st., Newark
Hayes, Gerald W., 96 N. Walnut st., E. Orange
Hubach, M. F., 401 Franklin st., Bloomfield
Jennings, Robt. E., 143 Park st., East Orange
Johnson, O. W., Rugby, North Dakota
Jost, Franz, 98 Washington st., East Orange
Katzin, Eugene M., 50 Baldwin av., Newark
Kimmel, Charles, 10 Johnson av., Newark
Kingsbury, Marguerite, 207 Summer av., Newark
Lee, John J., 66 Central av., Orange
Lewis, Leon, 190 Clinton av., Newark
Liccese, Emanuel, 635 Summer av., Newark
Licks, Frederick C., 63 Taylor pl., South Orange
Macaluso, D., 531 Joralemon st., Belleville
Massengill, F., 31 Clinton st., Newark
Masterson, John F., 94 Myrtle av., Irvington
Miller, Nathan, 990 Sanford av., Irvington
Morrow, Chas. S., 321 S. 9th st., Newark
Mullin, Eugene P., 515 Sanford av., Newark
Nacca, Carl A., 86 N. Essex av., Orange
Nevius, Wm. B., 61 N. Fullerton av., East Orange
Pattyson, R. A., 144 Harrison st., East Orange
Paul, H. Carl, 24 Hanford pl., Caldwell
Payne, Guy, Jr., 9 So. Prospect st., Verona
Pilloni, Louis, 27 Park pl., Bloomfield
Quad, Clifford W., 53 Northfield av., West Orange
Robbins, Alex., 24 Johnson av., Newark
Rosamilia, Robt. E., 480 N. 7th st., Newark
Sherman, Arthur E., 25 Prospect st., East Orange
Sisson, Nelson W., 144 Harrison st., East Orange
Statman, Arthur J., 337 Hawthorne av., Newark
Stiles, Clarence C., 114 N. 19th st., East Orange
Tillis, Herman H., 11 Bergen st., Newark
Tirico, Jos. G., 791 Bloomfield av., Montclair
Trautwein, C. F., 19 Treacy av., Newark
Walsh, Chas. R., 24 Glannan road, Livingston
Ward, Elizabeth B., 112 Chancellor av., Newark
Wolf, Raymond E., 47 Lawrence av., West Orange
Zimmerman, Coler, 82 N. Arlington av., E. Orange
Zybulewski, E. A., 410 Bergen st., Newark

Number of Associate Members, 71.

Number of active members and basis of representation, 746, March 15, 1935.

Albert E. Frey, Dec., 1934
James Spencer Brown, Aug. 18, 1934
Clarence Van R. Bumsted, May 27, 1934
William M. Goodwin, Nov. 21, 1934
Chauncey B. Griffiths, Mar. 23, 1934
William Francis Hoeler, Apr. 8, 1934
M. Lional Ignatoff, Dec. 25, 1934
Boris Nochin Margulis, Aug. 7, 1934
Henry Thomas Obuchowski, Aug. 8, 1934
Robert Cecil Potter, Feb. 6, 1934
Henry Woodbridge Thayer, Mar. 28, 1934
John Wesley Tildon, Feb. 2, 1935
Russell Edward Titman, Sept. 8, 1934
William H. Van Geison, Sept. 8, 1934
Watson L. Rodeman, Nov., 1934
Harry Blatt Harris, Feb. 11, 1935.
Albert B. Nash, March 10, 1935
James H. Tramor, March 15, 1935

Resignations

Rigg, Samuel B.
Fattel, Henry C.

Transfers In

James, Wm. Lloyd, from Bergen Co. Society, N. J.
Kingsbury, Marguerite, Richmond Co. Society, N. Y.
Lewis, Leon, from Phil. Co. Society
Simon, Henry, from Union Co. Society, N. J.

Transfers Out

Mullins, Roy L., to Hunterdon Co. Society
Rapp, Robt. F., to Hunterdon Co. Society
Stage, Earl, to Morris Co. Society
Weisman, Jos. C., to Queens Co., N. Y., Society

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on the third Thursday of each month, except June, July and August. Annual Meeting in November. Annual Social Session in October.

President, Ristine, E. R. Westville

Vice-President, Lummis, M. F. Pitman

Secretary-Treasurer, Hollinshed, Ralph K., Westv'le

Reporter, Diverty, Henry B., Woodbury

Censors, Stout, H. W., Chairman, Wenonah
Knight, I. W., Pitman
Ulmer, Chester I., Gibbstown

Active Members

Ashcraft, Samuel F., Mullica Hill
Barrows, Victor I., Pitman
Black, Alan B., Clarksboro
Bowersox, C. A., Woodbury
Brewer, William, Woodbury
Burkett, William, Pitman
Campbell, Duncan, Woodbury
Carpenter, William H., Woodbury
Crain, W. E., Woodbury
Diverty, Henry B., Woodbury
Downs, Elwood E., Woodbury
Fishler, C. F., Clayton
Fooder, H. M., Williamstown
Gairdner, T. M., Gibbstown
Hillegas, E. J., Mantua
Hollinshed, Ralph K., Westville
Knight, I. Warner, Pitman
Livengood, B. A., Swedesboro
Lummis, M. F., Pitman
Moore, Ralph L., Woodbury
Pedrick, Charles D., Glassboro
Pedrick, William W., Glassboro
Pegau, Paul, Woodbury
Rhoads, S. Creadick, Westville
Ristine, Edwin R., Westville
Rogers, Dorothy, Woodbury
Ruttenberg, Louis, Mantua
Sheets, C. C., Paulsboro
Sherman, Fuller G., Woodbury
Sinexon, Harry L., Paulsboro
Sooy, L. T., Pitman

Stewart, Irving J., Swedesboro
Stout, Harry Wilson, Wenonah
Ulmer, Chester I., Gibbstown
Underwood, J. Harris, Woodbury
Wandall, F. G., Clayton
Weems, Don B., Wenonah
Wood, Oram A., Paulsboro
Wright, H. W., Williamstown

Number of active members and basis of representation, 39.

100 per cent paid up membership, March 1, 1935.

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, the meeting to be held on the next day. Annual Meeting in October.

President, Chapman, Elias J., Jersey City

Vice-President, Schuck, Traugott J., Hoboken

Secretary, Brennock, Thomas McG., Jersey City

Treasurer, Kelley, Charles B., Jersey City

Reporter, Connell, John N., Jersey City

Censors, Cassidy, J. M., Jersey City
Jaffin, A. E., Jersey City
Ballinger, R L., Arlington

Active Members

Adams, Samuel, 29 Highland av., Jersey City
Adler, Joseph. 933 Ave. C, Bayonne
Africano, J. V., 4246 Hudson blvd., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Alexander, Hugo, 928 Hudson st., Hoboken
Allen, Isaac L., 521 Palisade av., Union City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Andreae, Paul, 52 Warner av., Jersey City
Angelo, Jos. A., 1190 Paterson Plank rd., Secaucus
Aria, Michael, 31 Glenwood av., Jersey City
Arlitz, William J., 107 Newark st., Hoboken
Aronowitz, Harry L., 11 E. 42nd st., Bayonne
Ash, Arthur F., 710 Boulevard East, Weehawken
Atwell, David R., 920 Hudson st., Hoboken
Auriemma, Michael, 419 Adams st., Hoboken
Axford, W. H., Chester
Baechler, Jules, 439 16th st., West New York
Bahnson, Conrad M., 170 Bowers st., Jersey City
Bailyn, Emanuel, 331 16th st., West New York
Ballinger, Reeve L., 659 Kearney av., Arlington
Banach, Leon, 2747 Boulevard, Jersey City
Barbarito, William N., 135 Bentley av., Jersey City
Barishaw, S. B., 5 Bentley av., Jersey City
Barrett, A. F., 835 Montgomery st., Jersey City
*Bauman, John J., 2672 Boulevard, Jersey City
Behrens, Herman, 312 Webster av., Jersey City
Ben-Asher, Solomon, 260 Bergen av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Berlin, J. I., 9 Gifford av., Jersey City
*Binder, Joseph, 422 Bergen av., Jersey City
Binder, Wm. A., 975 B'way, Woodcliff
Bitten, Robert M., 33 Romaine av., Jersey City
Blakey, A. P., 155 Wegman Parkway, Jersey City
*Blanchard, O. R., 37 Clinton av., Jersey City
Bookrajian, Edw. N., 5459 Hudson blvd., N. Bergen
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Bowyer, Frank F., 50 Gifford av., Jersey City
Brady, Thos. S., 678 Avenue C, Bayonne
Brady, William, 403 46th st., Union City
Brandenberg. Leo W., 4260 Boulevard, Union City
Brauer, Selig, 234 Bergen av., Jersey City
Braunstein, S. C., 424 13th st., West New York
Braunstein, Wm. P., 831 Boulevard E., W'hawken
Brennock, Thos. McG., 3 Webster av., Jersey City
Brick, G. J., 43 Cottage st., Jersey City
Broesser, H. V., 105 Newark av., Hoboken
Brooke, W. W., 915 Ave. C, Bayonne
Brophy ,Francis X., 2511 Boulevard, Jersey City
Brozdowski, John J., 554½ Jersey av., Jersey City
Bruder, A. J., 344 Fairmount av., Jersey City
Butler, Vincent P., 921 Bergen av., Jersey City
Cannon, Edw. A., 5360 Hudson blvd., N. Bergen
Caridi, Salvatore, 465 Bergenline av., West New Y'k
Carr, Mary B., 1 Astor pl., Jersey City
Chapman, E. J., 203 Danforth av., Jersey City
Chayes, Sidney, 980 Ave. C, Bayonne
Christian, Henry A., 111 Fairview av., Jersey City
Clark, Chas. C., 461 New York av., Union City
Cobham, James L., 78 Brinkerhoff st., Jersey City
Cohen, Harry F., 660 Jersey av., Jersey City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 714 Park av., Hoboken
Cohen, Samuel A., 112 Mercer st., Jersey City
Comora, Herman C., 317 16th st., West New York
Connell, Emmet J., 2227 Blvd., Jersey City
Connell, John, 977 Summit av., Jersey City
Connell, John N., 26 Carlton av., Jersey City
Connolly, Thos. W., 921 Bergen av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Cosgrove, Samuel A., 254 Union st., Jersey City
Cracco, Fred'k A., 51 Palisade av., Union City
Cropper, Chas. W., 2540 Hudson Blvd., Jersey City
Crowley, Leo F., 148 Belmont av., Jersey City
Culver, Geo. M., 25 Glenwood av., Jersey City
Culver, S. Herbert, 75 Magnolia av., Jersey City
Curtis, Grant P., 312 36th st., Union City
D'Acierno, P., 346 Palisade av., Union City
Daly, E. J., 921 Bergen av., Jersey City
Davey, Thomas N., 41 West 33rd st., Bayonne
Decker, Clinton L., 40 S. Kingman rd., S. Orange
DeFuccio, C. P., 47 Glenwood av., Jersey City
DeMeritt, C. L., 1225 Bloomfield st., Hoboken
Dexter, Harriet E. T., 903 Avenue C, Bayonne
Dillingham, W. I., 431 15th st., West New York
Dodson, Louis, 592 Jersey av., Jersey City
Dolganos, Moses, 268 Palisade av., Jersey City
Donohoe, Lucius F., 140 West 8th st., Bayonne
Doran, Ralph J., 200 11th st., Hoboken
Doran, Wm. G., 921 Bergen av., Jersey City
Duckett, Warren, 21 Carlton av., Jersey City
Dukes, H. R., 220 Kearny av., Kearny
Eckert, William, 672 Palisade av., Union City
Edgar, Joseph A., 71 Congress st., Jersey City
Edwards, Lena F., 358 Pacific av., Jersey City
Enright, J. G., 25 Kensington av., Jersey City
Evans, James L., 893 Park av., North Bergen
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Farr, J. C., 75 10th st., Hoboken
Fattel, Henry C., 256 Montgomery st., Jersey City
Feit, Herman, 921 Bergen av., Jersey City
Fellman, M., 118 Jewett av., Jersey City
Ferenczi, Louis J., 33 Edwards st., Bayonne
Fineberg, Jacob, 50 Glenwood av., Jersey City
Finke, Chas. H., 317 York st., Jersey City

Finn, Frederick A., 921 Bergen av., Jersey City
Flaherty, M. E., 36 Glenwood av., Jersey City
Flichtenfeld, Morris, 283 4th st., Jersey City
Forman, H. S., 640 Bergen av., Jersey City
Frank, Morris, 920 Ave. C, Bayonne
Franklin, I. Harold, 191 Palisade av., Jersey City
Franklin, Louis, 191 Palisade av., Jersey City
Freile, Wm., 25 Tonnele av., Jersey City
Frundt, Oscar C., 92 Bartholdi av., Jersey City
Furlonge, H. Rowland, 333 Forrest st., Jersey City
Gardner, John W., 636 Ocean av., Jersey City
Ghee, Euclid P., 115 Clairmont av., Jersey City
Gille, Hugo, 149 Congress st., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleeson, Wm. John, 37 Monticello av., Jersey City
Godlin, David R., 610 36th st., N. Bergen
Gonzales, W. G., 638 Hudson st., Hoboken
Gordon, I. L., 1815 Boulevard, Jersey City
Goudy, E. S., 187 Kearny av., Kearny
Gould, J. H., 696 Ave. C, Bayonne
Greenberg, Philip, 1902 Hudson blvd., Jersey City
Greene, Albert D., 195 Palisade av., Union City
Greissinger, Karl, 422 20th st., West New York
Hall, Percy O., 254 Union st., Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halligan, Harold J., 254 Montgomery st., Jersey C'y
Halpern, Sophia L., 271 Palisade av., Union City
*Hammill, E. J., 50 Journal Sq., Jersey City
Hammer, Walter P., 322 15th st., West New York
Hardenberg, D. S., 347 Communipaw av., Jersey C'y
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. A., 777 Boulevard East, Weehawken
Harvey, John W., 818 Ave. C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jer. City
Heilbrunn, Julius, 135 Belmont av., Jersey City
Heintzelman, B. S., 19 W. 33rd st., Bayonne
Hekimian, J. H., 468 Palisade av., Weehawken
Hernandez, Manuel, 1974 Hudson blvd., Jersey City
Herradora, J. R., 921 Bergen av., Jersey City
Higgins, G. L., 94 Lembeck av., Jersey City
Higgins, Thos. A., 2616 Hudson blvd., Jersey City
Hill, William F., 108 Grand st., Jersey City
Hoffman, P., 2672 Boulevard, Jersey City
Hollywood, Jas. L., 1818 Hudson blvd., Jersey City
Hommell, P. E., 689 Bergen av., Jersey City
Hoops, Harold J., 2203 Blvd., Jersey City
Introcaso, D. A., 45 Crescent av., Jersey City
Ishkhanian, N. I., 656 Palisade av., West New York
Jacks, Oscar, 476 Mercer st., Jersey City
Jacques, J. Eugenia, 74 Waverly st., Jersey City
Jaffe, Herman, 2600 Blvd., Jersey City
Jaffin, A. E., 41 Emory st., Jersey City
Jentz, John H., 63 Sherman pl., Jersey City
Jones, J. Morgan, Valley rd., R.F.D., Oakland
Joseph, B. M., 2771 Boulevard, Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Justin, J. Clement, 413 16th st., West New York
Kearney, John V., 410 Bergenline av., West N. Y.
Keegan, Thos. D., 76 Bentley av., Jersey City
Kelley, Chas. B., Trust Co. of N. J. Bldg., Jersey C'y
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kelly, James E., 160 Wegman Pkwy., Jersey City
Kerdasha, Geo. W., 131 31st st., N. Bergen
Kiely, Eugene M., 926 Hudson st., Hoboken
King, Geo. W., Hud. Co. Hos. for Insane, Secaucus
Klaus, Henry, 435 Palisade av., Union City
Klugman, Louis W., 375 Ave. C, Bayonne
Kolb, J. M., 725 10th st., Union City
Kooperman, Barnett, 432 16th st., West New York
Kooperstein, Samuel, 395 Ogden av., Jersey City
Koppel, Joseph, 921 Bergen av., Jersey City
Koppel, Leo A., 921 Bergen av., Jersey City
Kresch, Philip, 42 W. 22nd st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Lange, Louis C., 50 Clifton ter., Weehawken
Largay, Arthur O., 937 Ave. C, Bayonne
Larkey, Charles J., 700 Ave. C, Bayonne
Lawsing, G. Condi, 443 22nd st., West New York
Lefkowitz, Jacob H., 445 20th st., West New York
Leining, Albert, 1 4th st., Weehawken
Leir, J. Krevin, 9 Garrison av., Jersey City
Lemmerz, Theodore H., 141 Magnolia av., Jer. City
Levine, G. I., 2107 Boulevard, Jersey City
Lewis, Livingston L., 712 Washington st., Hoboken
Linden, Mortimer H., 45 Clendenny av., Jersey City
Lindroth, Lawrence V., 4633 Hudson Blvd., N. Bergen
Londrigan, Jos. F., 535 Washington st., Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Luczynski, Edw. L., 38 W. 26th st., Bayonne
Luippold, E. J., 85 Columbia ter., Weehawken
Lupin, Edward E., 727 Ave. C, Bayonne
Lynch, Roland J., 93 Fairview av., Jersey City
McDede, J. Searle, 215 Ege av., Jersey City
McDonald, F. R., 79 Summit av., Jersey City
McLean, Herbert E., 92 Fairview av., Jersey City
McLean, Hugh A., 414 17th st., West New York
*McLean, John J., 92 Fairview av., Jersey City
McLoughlin, Frank J., 558 Jersey av., Jersey City
Macohia, Benj. J., 262 Montgomery st., Jersey City
Madden, Wm., L., 83 Gifford av., Jersey City
Mallalieu, Frank W., 16 Monticello av., Jer. City
Mangone, Geo. F., 171 Palisade av., Union City
Maras, Peter E., 80 Tonnele av., Jersey City
Markowitz, B. B., 2157 Boulevard, Jersey City
Markowitz, Irwin, 2157 Boulevard, Jersey City
Marks, David M., 298 4th st., Jersey City
Marshak, Martin I., 679 Ave. C, Bayonne
Matera, Joseph, 506 Garden st., Hoboken
Mathesheimer, J. L., 280 Old Bergen rd., Jer. City
Matthews, Wm. J., 938 Hudson st., Hoboken
Maver, Wm. W., 532 Bergen av., Jersey City
Mead, Walter G., 699 Kearny av., Arlington
Meehan, Geo. Edw., 117 Mercer st., Jersey City
Meltsner L., 904 Hudson st., Hoboken
Mendelsohn, Lewis, 272 Montgomery st., Jer. City
Mersheimer, Chris. H., 15 Reservoir av., Jer. City
Meyer, Wm., 436 New York av., Union City
Miller, M. H., 311 16th st., West New York
Miner, Donald, 921 Bergen av., Jersey City
Monaghan, Wm., J., Hudson Co. Hospital, Secaucus
Morley, Grace C., 440 Palisade av., Weehawken
Morris, D. G., 11 W. 26th st., Bayonne
Morrone, John A., 233 Bowers st., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Murphy, Edward A., 1 Britton st., Jersey City
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 374 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jer. City
Murray, Jos. A., 765 Ave. C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 702 Ocean av., Jersey City
Mutter, Alfred A., 75 Beech st., Kearny
Myerson, Noah, 428 15th st., West New York
Nafash, M. Shafesk, 402 21st st., Union City
Nalitt, David I., 28 W. 33rd st., Bayonne
Nattrass, R. B., 204 11th st., Hoboken
*Nay, Chas. S., 164 Palisade av., Jersey City
Nevin, John, 131 Kensington av., Jersey City
Newman, Abraham J., 70 Sherman pl., Jersey City
Nicholson, Frank P., 895 Summit av., Jersey City
Norton, James F., 299 Varick st., Jersey City
Nuse, Edward F., 50½ Jersey av., Jersey City
Ockene, Abraham, 495 Palisade av., Union City
O'Connor, B. A., 314 North 4th st., Harrison
O'Connor, John J., 434 New York av., Union City
Oestman, A. W., 932 Summit av., Jersey City
O'Gorman, M. W., 880 Bergen av., Jersey City
O'Hanlon, George, Jersey City Medical Centre
Older, Benj., 435 New York av., Union City
Olpp, A. E., 318 Bergenline av., Union City

O'Neill, John H., 270 Montgomery st., Jer City
Opdyke, L. A., 55 Clinton av., Jersey City
O'Shea, John J., 135 Shippen st., Weehawken
Oshrin, Henry, 750 Park av., West New York
Ovens, R. C., 675 Bergen av., Jersey City
Owen, Logan S., 938 Hudson st., Hoboken
Pacicco, Michele, 376 Monmouth st., Jersey City
Pagliughi, John J., 401 18th st., Union City
Pearlstein, Frank, 325 16th st., West New York
Pellarin, John D., 493 New York av., Union City
Pentel, Louis S., 307 16th st., West New York
Perkel, Louis L., 3263 Boulevard, Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Peters, E. A. P., 394 Bergen av., Jersey City
Peterson, C. A., 921 Washington st., Hoboken
Piltz, Geo. F., 153 25th st., Guttenberg
Pindar, Fred S., 960 Park av., N. Bergen
Pindar, Wm. A., 975 Broadway, Woodcliff
Pinkerton, Wm. A., 854 Ave. C, Bayonne
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 5407 Hudson blvd., N. Bergen
Pollak, B. S., Hud. Co. Tub. San., Secaucus
Potter, Benj. Paul, Hud. Co. Tub. San., Secaucus
Povalski, Alex. W., 1925 Boulevard, Jersey City
Purdy, Chas. H., 35 Highland av., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Pyle, Wallace, 15 Exchange pl., Jersey City
Quigley, Frederic J., 4622 Boulevard, Union City
Quinn, John J., 707 Bergen av., Jersey City
Rector, Joseph M., 681 Bergen av., Jersey City
Reingold, Alexander, 221 Garden st., Hoboken
Rieck, Walter R., 377 Kearny av., Kearny
Rieman, Aloysius, 3566 Boulevard, Jersey City
Robbins, Henry B., 144 Mercer st., Jersey City
Roberts, Edgar W., 760 Palisade av., W. N. Y.
Rosecrans, James H., 826 Hudson st., Hoboken
Rosenberg, Albert B., 1921 Blvd., Jersey City
Rosenberg, J., 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rowe, Norman L., 828 Grand st., Jersey City
Rundlett, Emelie V., 79 Prospect st., Jer. City
Ruoff, Andrew C., 494 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Sacco, Anthony G., 440 New York av., Union City
Sachs, Wilbert, 921 Bergen av., Jersey City
Santangelo, Stephen, 304 Varick st., Jersey City
Santosky, Benjamin B., 162 Bergen av., Jer. City
Saradarian, Albert V., 481 New York av., Union City
Schapiro, Joseph, 712 Palisade av., Union City
Schenker, B. N., 246 5th st., Jersey City
Schept, Samuel S., 523 37th st., Union City
Schlein, August, 707 Park av., Hoboken
Schneckendorf, Samuel, 179 Harrison av., Jer. City
Schneider, Louis A., 412 17th st., West New York
Schuchner, Wm. F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 9th st., Hoboken
Schurman, E. W., 710 Ocean av., Jersey City
Schwarz, B. T. D., 2787 Hudson blvd., Jersey City
Schwarz, Louis, 2695 Boulevard, Jersey City
Schwartz, Henry J., 5560 Hudson blvd., N. Bergen
*Schwarz, W. J. A., 269 Cator av., Jersey City
Sciorsci, Edw. F., 609 Bloomfield st., Hoboken
Scott, Samuel G., 141 Bergen av., Jersey City
Selinger, S., 413 16th st., West New York
Sesta, Jos., 242 Fulton av., Jersey City
Sexsmith, George H., 719 Ave. C, Bayonne
Shapiro, Maurice, 750 Ave. C, Bayonne
Shapiro, N. J., 192 Palisade av., Union City
Sheeran, Vincent J., 269 Jewett Ave., Jersey City
*Shipman, Frank C., 3663 Boulevard, Jersey City
Shook, B. E., 284 Bergen av., Jersey City
Shullman, N. L., 538 45th st., Union City
Siegler, Julius, 646 Bergen av., Jersey City
Simeone, Peter A., 555 38th st., Union City
Sirken, Chas., 887 Summit av., Jersey City
Smith, Alex. L., 2672 Boulevard, Jersey City
Snyder. J. E. C., 1023 Garden st., Hoboken
Solomon, David, 723 Ave. C, Bayonne
Spalding, H. J., 512 45th st., Union City
Spano, Frank, 320 47th st., Union City
Spath, George, 722 Hudson st., Hoboken
Spence, Henry, 2540 Blvd., Jersey City
Sprague, Seth B., 301 York st., Jersey City
Steadman, E. T., 107 Christopher st., Montclair
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robt., 3644 Boulevard, Jersey City
Stout, J. P., 165 Jewett st., Jersey City
Street, D. B., 27 Woodlawn av., Jersey City
Stuart, William C., 518 Hudson st., Hoboken
Sullivan, George F., 510 Hudson st., Hoboken
Sullivan, James A., 668 Jersey av., Jersey City
Sulouff, S. Henry, 662 Newark av., Jersey City
Sweeney, William J., 68 Clifton ter., Weehawken
Swiney, Merrill A., 325 Ave. C, Bayonne
Tannert, Carl H., 331 31st st., Woodcliff
Tataryan, H., 422 New York av., Union City
Temes, J. Howard, 293 Edge av., Jersey City
Thomas, Ralph B., 793 Montgomery st., Jersey City
*Thum, Ernest, 819 Ave. C, Bayonne
Tidwell, H. F., 229 16th st., West New York
Timlin, Jas. W., 64 Beech st., Arlington
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 495 New York av., Union City
Varriano, John L., 3258 Boulevard, Jersey City
Visconti, Jos. A., 711 Garden st., Hoboken
von Deesten, Henry T., 268 Palisade av., Jer. City
Vostrosablin, Nicholas A., 121 Grand st., Jer. City
Vreeland, Hamilton, 232 S. Irving st., Ridgewood
Vreeland, William N., 32 Bergen av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2761 Boulevard, Jersey City
Weber, Walter D., 305 23rd st., Union City
Wechsler, Joseph, 3342 Boulevard, Jersey City
Weiss, Abraham, 456 Palisade av., Wehawken
Weiss, M. J., 734 Ave. C, Bayonne
Welcher, H. A., 5446 Hudson Bulevard, N. Bergen
Wheeler, James A., 85 Van Reypen st., Jersey City
White, Hugh M., 901 Summit av., Jersey City
White, Thomas J., 50 Glenwood av., Jersey City
Wilcox, Frank A., 415 16th st., West New York
Wilkinson, George, 144 Old Bergen rd., Jersey City
Williamson, W. L., 22 W. 22nd st., Bayonne
Willis, John, 624 Pavonia av., Jersey City
*Winter, Daniel T., Jr., 8 Gifford av., Jersey City
Woelfle, Henry E., 69 Sherman pl., Jersey City
Woodruff, S. R., 16 Enos pl., Jersey City
Yeaton, W. L., 204 11th st., Hoboken
Yudkoff, Wm., 403 Boulevard, Bayonne
Zenneck, J. F., 17 Fourth st., Weehawken
Zitani, Alfred M., 937 Washington st., Hoboken

Associate Members

Aronowitz, Harry, 11 East 42nd st., Bayonne
Amdur, Louis A., 834 Westside av., Jersey City
Barone, Francis A., 175 Fulton st., Jersey City
Bonanno, Peter J., 518 35th st., N. Bergen
Borrone, Milton, 2695 Boulevard, Jersey City
Carpenter, Marcus E., 114 Storms av., Jersey City
Cieri, Daniel S., 315 Central av., Union City
Coughlin, John, 43 Arlington av., Jersey City
Cowan, Joseph H., 85 Van Reypen st., Jersey City
Danielson, John J., 65 Fulton st., Wehawken
De Fusco, G. T., 330 Newark av., Jersey City
D'Elia, Louis G., Wayne st., Jersey City
Dershimer, Frederick W., 546 Bergen av., Jer. City
De Yoanna, Alfred A., 508 4th st., Union City
Driscoll, Raymond, 919 Boulevard, Bayonne
Faber, Edward, 101 Wegman Pkwy., Jersey City
Federer, John J., 821 Blvd. East, Weehawken
Fialk, Harry, 996 Hudson av., Jersey City

Frank, Nathan, 186 Bowers st., Jersey City
Frieman, Hyman, 744 Ave. C, Bayonne
Garibaldi, Louis, 1016 Hudson st., Hoboken
Ghee, Peter F., 734 Ocean av., Jersey City
Gillen, James H., 14 Duncan av., Jersey City
Goldowsky, Ira, 1866 Boulevard, Jersey City
Goldstein, Joseph B., 3263 Boulevard, Jersey City
Gutman, Erwin K., 980 Summit av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Jaffe, Benjamin, 568 Bergen av., Jersey City
Kenyon, Thomas A., 14 4th st., Weehawken
Kimmel, M. Leonard, 142 Manhattan av., Jer. City
Klein, Allan, 5580 Hudson blvd., N. Bergen
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Landshof, Chas. A., 50 Glenwood av., Jersey City
Lipshutz, Chas., 804 Ave. C, Bayonne
Lobban, Robert B., 2595 Boulevard, Jersey City
Lynn, Irving I., 2554 Boulevard, Jersey City
Madison, Louis K., 358 Pacific av., Jersey City
Marano, Michael A., 508 4th st., Union City
Margulies, Chas., 203 Harrison av., Jersey City
McCarthy, John J., 606 35th st., N. Bergen
McLoughlin, John W., 39 W. 26th st., Bayonne
Mulvihill, Wm. J., 275 Hudson blvd., Bayonne
Ortolano, Jas. 522 Garden st., Hoboken
O'Sullivan, John R., 288 Chestnut st., Kearny
Penchansky, Samuel, 847 Ave. C, Bayonne
Riccairdelli, Emanuel, 75 Linden av., Jersey City
Riccollo, Anthony R., 833 Palisade av., Union City
Sandler, Samuel, 65 Tonnele av., Jersey City
Siegel, Sidney L., 29 Bentley av., Jersey City
Singer, Sina S., 1969 Boulevard, Jersey City
Snyder, Wm. J., 74 Columbia ter., Weehawken
Taft, Herman L., 25 Liberty pl., Weehawken
Valentine, E. J. J., 559 Summit av., Jersey City
Wallack, Eli A., 2012 Boulevard, Jeresy City

Honorary Members

Cropper, C. W., 2540 Boulevard, Jersey City

Transferred

Read, Jessie, to Union County Med. Society

Number of active members and basis of representation, 377, March 1, 1935.

Associate members, 55.

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

President, Baker, Philip W., High Bridge

First Vice-President, Lane, E. W., Bloombury

Sec. Vice-President, Harner, M. H., High Bridge

Secretary, Gramsch, Louis A., Glen Gardner

Treasurer, Closson, Edward W., Lambertville

Reporter, Gramsch, A. Louis, Glen Gardner

Censors, Tompkins, G. B.
Coleman, A. H.
English, S. B.

Active Members

Apgar, Francis A., Oldwich
Baker, Philip W., High Bridge
Boothby, I. R., Clinton
Christensen, A. H., Lebanon
Clark, Frank G., White House Station
Closson, Edward W., Lambertville
Coleman, A. H., Clinton
English, Samuel B., Glen Gardner
Fuhrmann, Barclay Stokes, Flemington
Fulper, Theodore B., Hampton
Gramsch, A. Louis, Glen Gardner
Hamilton, L. A. Lambertville
Harmon, B. M., Verona
Harmon, Harry M., Frenchtown
Harner, M. H., High Bridge
Heil, A. Arling, Milford
Henry, George, Flemington
Knox, Howard A., High Bridge
Lane, E. W., Bloomsbury
*Rufe, John J., High Bridge
Slavin, Paul, Glen Gardner
Tompkins, G. B., Flemington

Honorary Members

Ely, Lancelot, Somerville
Haussling, Francis R., Newark
Marsh, Elias J., Paterson
Morrison, J. Bennett, Newark
Newcomb, Marcus W., BrownsMills
Quigley, Frederick J., Union City
Scammell, Frank C., Trenton
Sommer, George N. J., Trenton

Number of active members and basis of representation, 21, March 1, 1935.

100 per cent paid up March 1, 1935.

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on the second Wednesday of each month, except July, August and September, at 8:30 P. M., in the Carteret Club at Trenton. Annual Meeting in December. Annual Banquet in November.

President, Cottone, R. J., Trenton

Vice-President, Stone, R. G., State Hos., Trenton

Secretary, Hutchinson, A. Dunbar, Trenton

Treasurer, North, Harry R., Trenton

Reporter, Hutchinson, A. Dunbar, Trenton

Censors, Seeley, R. B., Trenton
Mitchell, C. H., Trenton
Williams, G. W., Trenton

Active Members

Abey, W. J. H., 23 N. Delaware av., Pennington
Ackley, David B., 21 N. Clinton av., Trenton

Adams, Chas. F., 34 W. State st., Trenton
Applegate, Edw. T. R., 1125 Greenwood av., Trenton
Applestein, Robert, 569 E. State st., Trenton
Aronis, H. R., 239 E. Hanover st., Trenton
Ashley, H. H., 192 W. State st., Trenton
Atkinson, Alvan W., 423 E. State st., Trenton
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, R. G., 908 W. State st., Trenton
Beairsto, E. B., 178 W. State st., Trenton
Belfer, J. J., 1235 Chambers st., Trenton
Belford, R. J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Belting, Arthur W., 202 E. Hanover st., Trenton
Berger, Harry, 921 S. Clinton av., Trenton
Berman, Jacob J., 409 Market st., Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 190 W. State st., Trenton
Blum, Joseph M., 128 Mill st., Trenton
Bowman, A. K., 272 Nassau st., Princeton
Buckley, R. T., Peddie School, Hightstown
Burroughs, Edmund W., 701 W. State st., Trenton
Carroll, C. Walter, 117 Centre st., Trenton
Carroll, W. V., 211 Academy st., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Child, Florence C., 317 City Hall, Trenton
*Clark, William A., Trenton
Cohen, C. C., 217 W. Hanover st., Trenton
Cohen, Herman, 1419 Hamilton av., Trenton
Cohen, Wm., 1007 Greenwood av., Trenton
Collier, Wm. S., 1000 S. Broad st., Trenton
Collins, Henry J., 1160 Hamilton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Connelly, John A., 212 W. State st., Trenton
Corio, Geo. A., 309 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Costill, Henry B., 371 Hamilton av., Trenton
Cottone, R. J., 683 Princeton av., Trenton
Cowlbeck, H. D., 224 W. State st., Trenton
Cox, Harold G., 208 Stockton st., Hightstown
D'Arcy, Walter E., 545 E. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davison, Royden W., 205 W. State st., Trenton
Davenport, Irwin P., 194 W. State st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
D'Gianni, N. H., 911 Hamilton av., Trenton
Doranz. H. K., 38 S. Hermitage av., Trenton
*Douress, Philip C., 802 E. State st., Trenton
Drezner, H. L., 521 S. Warren st., Trenton
Elias, Elmer J., 827 S. Broad st., Trenton
Epstein, Harry H., 225 Perry st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Farmer, W. D., Church st., Allentown
Fee, Elam K., Main st., Lawrenceville
Fell, Alton S., 529 E. State st., Trenton
Fessler, A. J., 1544 S. Broad st., Trenton
Finegan, P. J., 1012 Hamilton av., Trenton
Forer, Robert, 247 Centre st., Trenton
*Franklin, C. C., 1012 Hamilton av., Trenton
Friedman, M. H., 526 N. Clinton av., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Funkhouser, Edgar B., State Hospital, Trenton
Goldberg, Benjamin M., 1156 E. State st., Trenton
Gordon, Clark H., 808 E. State st., Trenton
Graham, E. E., P. O. Box 195, Yardville
Guglielmelli, A. D., 449 Hamilton av., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Hammell, F. M., 137 S. Main st., Allentown
Haney, John J., 167 Cooper st., Trenton
Harman, J. R., 1819 S. Broad st., Trenton
Harman, Wm. J., 740 W. State st., Trenton
Hiden, J. C., 199 Nassau st., Princeton
Hirschfield, B. A., 1404 Greenwood av., Trenton
Holland, John A., 54 Prospect st., Trenton
Hunter, F. D., 3620 Nottingham Way, Trenton
Hutchinson, A. D., 913 W. State st., Trenton
Hutchinson, G. F., Hamilton Square
Iams, Samuel H., 34 Mercer st., Princeton
Ireland, A. G., N. J. Dept. Education, Trenton
Ivins, Wm. C., 214 E. Hanover st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Kachdorian, Vartan, 930 Brunswick av., Trenton
Koplin, Nathan H., 142 W. State st., Trenton
*Kuhl, Paul E., 48 N. Clinton av., Trenton
Kustrup, J. F., 1435 S. Broad st., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lettiere, A. J., 320 Centre st., Trenton
Levin, Louis, 140 W. State st., Trenton
Little, William R., 493 W. State st., Trenton
MacDermid, L. E., 506 Farnsworth av., Bordent'n
MacFarland, Burr W., Broad St.Bk. Bldg., Trenton
McCandliss, W. K., State Hospital, Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, F. A., 212 N. Warren st., Trenton
McGuire, Jas. J., 122 W. State st., Trenton
Majeski, H. J., 1015 Brunswick av., Trenton
Marotte, Chas. L., 1417 S. Clinton av., Trenton
Martin, E. L., 293 Nassau st., Princeton
Means, P. B., State Hospital, Trenton
Mewborne, Edw. B., Lawrenceville
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, G. H., N. Main st., Cranbury
Mitchell, Chas. H., 1100 W. State st., Trenton
Mitskas, T. V. J., Main st., Crosswicks
Moriconi, A. F., 438 Hamilton av., Trenton
Mras, J. N., State Hospital, Trenton
Murphy, J. A., 467 Hamilton av., Trenton
North, Harry R., 160 W. State st., Trenton
O'Rourke, James J., 871 Stuyvesant av., Trenton
Panteleone, Joseph, 504 Hamilton av., Trenton
Parker, H. Norton, 72 N. Clinton av., Trenton
Pessel, J. F., 224 W. State st., Trenton
Peterson, W. R., 224 W. State st., Trenton
Phillips, Robert H. C., 144 W. State st., Trenton
Pierson, Carl L., 178 W. State st., Trenton
Pierson, J. R., 224 W. State st., Trenton
Pierson, Theodore A., Hopewell
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 198 W. State st., Trenton
Poyas, M. L., 1871 Pennington rd., Trenton
Proctor, Francis E., 1245 Greenwood av., Trenton
Purcell, Ernest F., 800 Stuvesant av., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
Rainey, W. G., 34 Bayard Lane, Princeton
Reisinger, P. B., 369 W. State st., Trenton
Rogers, Alvin S., 126 N. Warren st., Trenton
Rogers, Lawrence H., Municipal Colony, Trenton
Rogers, W. N., 1255 Brunswick av., Trenton
Rowan, Henry M., 224 W. State st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, B. B., 110 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Schroeder, H. J. L., 134 W. State st., Trenton
Seeley, Roy B., 78 N. Clinton av., Trenton
Seitzick, Hannah E., 733 Hamilton av., Trenton
Sekerak, Albert J., 977 S. Broad st., Trenton
Shaw, Jos. B., 119 S. Warren st., Trenton
Sica, Samuel, 431 E. State st., Trenton
Sill, John B., 1129 Hamilton av., Trenton
Silver, E. Drew, Hightstown
Silver, George A., Hightstown
Sinton, John Y., Imlaystown
Sista, Chas. R., 476 Hamilton av., Trenton
Slack, Clarence J., 230 W. State st., Trenton
Smith, Houghton, 1063 S. Clinton av., Trenton
Smith, W. Henley, 34 W. State st., Trenton
Sommer, Geo. N. J., 120 W. State st., Trenton
Spradley, J. B., State Hospital, Trenton
Stein, L. A., 226 W. State st., Trenton
Stone, R. G., State Hospital, Trenton

Summers, A. D., 180 Nassau st., Princeton
Swern, Nathan, 130 W. State st., Trenton
Taylor, Walter A., 450 Rutherford av., Trenton
Tempesto, Jos. A., 306 Hamilton av., Trenton
Treiber, Benj. A., 626 Perry st., Trenton
Turner, Irvine F. P., 224 W. State st., Trenton
Urbaniak, H. S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
*Van Neste, George V., Hopewell
Vanneman, Joseph S., 180 Nassau st., Princeton
Walsh, Thomas J., 1158 E. State st., Trenton
Warter, P. J., 626 W. State st., Trenton
Waters, Chas H., 928 W .State st., Trenton
Watson, Fred S., 238 W. State st., Trenton
Watov, S. E., 744 Beatty st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, B. R., 1052 Stuyvesant av., Trenton
Weisler, Howard, 491 Centre st., Trenton
West, Edgar L., 443 E. State st., Trenton
Wikoff, J. L., 799 Pennington av., Trenton
Wilbur, William Lane, Hightstown
Wilkes, LeRoy A., 833 Berkeley av., Trenton
Williams, Geo. W., 217 N. Warren st. ,Trenton
Williams, Harry D., 527 E. State st., Trenton
Wright, Howard E., P. O. Box 276, Princeton
Yaeger, Leslie A., 470 Hamilton av., Trenton
Yazujian, Dikran M., 562 E. State st., Trenton
Zandt, Frederick B., 2 Mercer st., Trenton
Zentsner, M. R., 1271 Hamilton av., Hamilton Sq're
Zimskind, Joshua N., 210 W. State st., Trenton

Honorary Members

*Clark, Wm. A., Trenton
Moore, R. H., Trenton

Associate Members

Cella, Chas. F., 335 Hamilton av., Trenton
Camper, T. T., Camden, Delaware
Carabelli, A. A., 1024 Chambers st., Trenton
Chesner, Wm., A., 1111 Hamilton av., Trenton
Dimun, J. T., 960 S. Broad st., Trenton
Fine, Sidney G., N. J. State Hospital, Trenton
Franzoni, A. E., 938 Brunswick av., Trenton
Friedman, Max, 822 Chambers st., Trenton
Hawke, Edward K., N. J. Hospital, Trenton
Klein, Alexander, 961 S. Broad st., Trenton
Klempner, Paul, 414 Market st., Trenton
Kondor, Jos. S., 978 S. Broad st., Trenton
Kuch, Edward, 991 S. Broad st., Trenton
Matthews, Clifford B., 709 Greenwood av., Trenton
Miller, Samuel R., 31 Main st., Pennington
Munro, Jeannette, 293 Nassau st., Princeton
Nonziato, F. A., 50 Center st., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Seidelman, S. E., 1919 Greenwood av., Trenton
Sommer, G. N. J., Jr., 120 W. State st., Trenton
Storaci, Frank S., 749 Hamilton av., Trenton
Swertfeger, H. W., 106 W. Broad st., Hopewell
Waldron, Edw. L., 126 W. State st., Trenton
Wilner, Arthur A., 203 Bellevue av., Trenton
Wittenborn, W. F. J., 1613 Brunswick av., Trenton

100 per cent paid up membership, March 1, 1935.

Number of active members and basis of representation, 178.

Associate members, 25.

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, September to June inclusive. Annual Meeting in December.

President, Haywood, Henry, New Brunswick

Vice-President, Mann, Jacob J., Perth Amboy

Secretary, Taber, Fred S., New Brunswick

Treasurer, Smith, Marshall, New Brunswick

Reporter, Rothschild, Karl, New Brunswick

Active Members

Anderson, John F., 195 College av., N. Brunswick
Applegate, Grov. T., 116 Livingston av., N. Br'nsw'k
Avery, Phillip S., Middlesex Gen Hos., N. Bruns.
Basset, Lavern C., 320 New Market rd., Dunellen
Beekman, Jesse H., Sayreville
Berkow, Samuel G., 138 Market st., Perth Amboy
Boulden, George P., P. O. Box 422, New Brunswick
Breslow, S., 111 Market st., Perth Amboy
Brody, Morton S., 84 Bayard st., New Brunswick
Brown, Fred L., 67 Livingston av., N. Brunswick
Burnett, Chas. B., Main st., South River
Calvin, Charles, 80 Commerce st., Perth Amboy
*Carroll, Edgar, Dayton
Clarke, F. W., 47 Bayard st., New Brunswick
Cohen, N. B., 232 State st., Perth Amboy
Collins, James J., Main st., Woodbridge
Condon, W. J., 50 Livingston av., New Brunswick
Cooper, I. J., 71 Livingston av., New Brunswick
Cottrell, Judson G., 159 Market st., Perth Amboy
Cronk, E. Irving, 57 Livingston av., N. Brunswick
Csema, E. J., 151 Somerset st., New Brunswick
Dieker, Howard, 78 Main st., South River
Downs, L. S., 76 Washington av., Carteret
Eulner, E. H., 216 Henry st., Perth Amboy
Fagan, Jas. L., 51 Bayard st., New Brunswick
Falcone, C., 197 Sanford st., New Brunswick
Fanelli, Antonio, 469 Lowrie st., Perth Amboy
Faulkingham, R. J., 61 Livingston av., N. Bruns.
Feher, L. A. M., 177 Somerset st., N. Brunswick
Fine, H. P., 185 Market st., Perth Amboy
Fishkoff, A., 360 State st., Perth Amboy
Fithian, Geo. W., 266 High st., Perth Amboy
Forney, Norman N., Main st., Milltown
Fox, S. W., Ford av., Fords
Gauzza, Valentine P., Fords
Goldberg, H. C., 182 Market st., Perth Amboy
Goldberg, I., 303 N. Washington av., Dunellen
Grieve, James, 88 Market st., Perth Amboy
*Gutman, Benj., 51 Livingston st., New Brunswick
Gutowski, Jos. M., 433 Brace av., Perth Amboy
Haight, Harry W., Raritan av., New Brunswick
Haywood, Henry, 3 Elm row, New Brunswick
Henry, Frank C., 254 State st., Perth Amboy
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hilker, G. F., 258 Maple st., Perth Amboy
Hinton, S. H., Parlin
Hofer, Clarence J., Metuchen
Hoffman, Florentine M., 91 Bay'd st., N. Bruns.
Howley, Barth M., 419 George st., N. Brunswick
Hunt, A. C., 625 Middlesex av., Metuchen
Hunt, Melvin M., 16 Jackson st., South River
Karshmer, Nathan, 422 George st., N. Brunswick
Kemeny, Imre, 48 Pulaski av., Carteret
Kinney, Seldon T., 250 Main st., South Amboy
Kleiber, Estelle, 139 New st., New Brunswick
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick

Kler, J. H., Rutgers Univer. Infirmary, N. Bruns.
Koelsch, F. J., 14 Patrick st., New Brunswick
Kovarsky, A. E., 255 State st., Perth Amboy
Kraczyk, M. J., 207 Whitehead av., South River
Kramer, S. E., 121 Market st., Perth Amboy
Leonard, Geo. F., 65 N. 5th av., New Brunswick
London, William M., 255 State st., Perth Amboy
Long, Pauline A., 20 Livingston av., N. Brunswick
Longbothum, George T., 208 Dunellen av., Dun'll'n
Lund, John L., 267 High st., Perth Amboy
MacDowell, J. L., 113 Market st., Perth Amboy
McCormick, Wm. H., 266 Market st., P. Amboy
McGovern, John F., 24 Livingston av., N. Brunswick
McKiernan, Robt. L., 97 Bayard st., N. Brunswick
McKinstry, J. W., Jamesburg
McLeod, N. S., Raritan av., New Brunswick
Mann, Jacob J., 255 State st., Perth Amboy
Mark, Joseph, 102 Green st., Woodbridge
Marvin, Dorothy, 51 Livingston av., N. Brunswick
Meacham, Eugene A., 112 Stevens av., S. Amboy
Meinzer, Martin S., 147 Market st., Perth Amboy
Merrill, C. F., 16 N. 3rd av., H'ghl'd P'k, N. Bruns.
Messinger, Samuel J., 31 Roosevelt av., Carteret
Molitch, Matthew, Jamesburg
Morris, Carlyle, Metuchen
Nafey, Herbert W., 51 Livingston av., N. Bruns.
Naulty, Chas W., Jr., 403 High st., Perth Amboy
Nieman, S. Z., 92 Bayard st., New Brunswick
Pansy, Abraham A., 12 Jackson st., South River
Platt, Thomas H., 307 N. Washington st., Dunellen
Reason, John J., Roosevelt av., Carteret
Rona, Maurice, 159 Bayard st., New Brunswick
Rothschild, K., 49 Bayard st., New Brunswick
Rowland, John H., 159 New st., New Brunswick
Runyon, Lawrence P., 82 Somerset st., N. Bruns.
Sandella, J. F., 169 New st., New Brunswick
Scott, Fred W., 103 Bayard st., New Brunswick
Sender, Fannie, 129 Main st., South River
Sherman, W. E., George & Schureman, N. Bruns.
Shull, J. V., 84 Market st., Perth Amboy
Silk, Chas. I., 189 Rector st., Perth Amboy
Sirott, Barnett H., 413 State st., Perth Amboy
Slobodien, Benjamin F., 107 Market st., P. Amboy
Smith, A. L. M., 62 Bayard st., New Brunswick
Smith, J. Vincent, 463 State st., Perth Amboy
Spencer, Ira T., Main st., Woodbridge
Steffen, Charles T., Dunellen av., Dunellen
Strandberg, H., 94 Washington av., Carteret
Sullivan, Chas. J., 57 Paterson st., New Brunswick
*Swift, Edward M., Perth Amboy
Taber, F. H., 3 Elm row, New Brunswick
Toy, Calvert R., 22 Kirkpatrick st., N. Brunswick
Tyrrell, George W., 380 State st., Perth Amboy
Urbanski, Adrian X., 148 Market st., P. Amboy
Urbanski, M. F., 314 Washington st., Perth Amboy
Van Dyke, Benjamin S., Cranbury
Voorhees, Howard C., 43 Bayard st., N. Brunswick
Walker, R. B., 108 Church st., New Brunswick
Wantoch, Joseph, 14 Carteret av., Carteret
Weber, J. Francis, 264 Main st., South Amboy
Wetterberg, Louis F., 389 School st., Woodbridge
Wilentz, Wm. C., 188 Market st., Perth Amboy
Wilson, John G., 280 High st., Perth Amboy
Witmer, J. D., Elm av., Metuchen

Associate Members

Belafski, Henry A., 472 Rahway av., Woodbridge
Copleman, H. B., Middlesex Hosp., N. Brunswick
Davidson, M., Carteret
Degenhardt, Ira H., 51 Livingston av., N. Brunsw'k
Downing, P. E., Jamesburg
Glasser, Benjamin F., 316 George st., N. Brunsw'k
Goldberg, H. C., 182 Market st., Perth Amboy
Hauber, Eugene A., Sayreville
Horoschak, Anna, Woodbridge
Jablonski, J. J., South River
Jacobson, Murray B., 241 State st., Perth Amboy
Klein, Alexander, 210 Market st., Perth Amboy
Lazow, S. M., Broad st., Matawan
Lesh, Vincent O., 114 S. Stevens av., South Amboy
Lief, Lawrence H., Jamesburg
Paschal, G. W., Jr., 195 N. Main st., Milltown
Pellicane, Anthony J., 185 Livingston av., N. Bruns.
Pinnerman, Robert B., Bordentown av., S. Amboy
Rineberg, I. E., 93 Bayard st., New Brunswick
Stein, William, 71 Livingston av., New Brunswick
Szuch, N., 68 Main st., South River
Uhr, J. S., 131 Livingston av., New Brunswick
Watson, Price T., Milltown

Transferred

Stillwell, H. C., to Union County Medical Society

Number of active members and basis of representation, 119.

Number of Associate Members, 23.

100 per cent paid up March 1, 1935.

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on the fourth Wednesday of each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

President, Fairbanks, W. H., Freehold

Vice-President, Rullman, Walter, Red Bank

Secretary-Treasurer, Featherstone, D. F., Asb'y Pk.

Reporter, Pregnall, James P., Asbury Park

Censors, Brown, H. S. (Chairman)
Wilson, R. B.
Woromoff, Murray
Albright, Louis
Brown, K. G.

Active Members

Ackerman, Jas. F., 1010 Grand av., Asbury Park
Ackerman, Joseph, 404 Asbury av., Asbury Park
Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank Jos., 177 Garfield av., Long Branch
Appleton, Ralph, Farmingdale
Baeseman, R. W., 501 Grand av., Asbury Park
Bailey, Chas. P., 422 5th av., Lakewood
Baker, Elsworth F., State Hospital, Marlboro
*Beach, E. M., Long Branch
Becker, Sidney, Keyport
Beveridge, W. W., 100 Grand av., Asbury Park
Binder, Joseph, 149 Garfield av., Long Branch
Blaisdel, C. Byron, 489 Broadway, Long Branch
Bossone, Joseph E., 172 Garfield av., Long Branch
Boyd, John, East Front st., Red Bank
Brown, Harvey S., 5 Club pl., Freehold
Brown, Kenneth, 603 Asbury av., Asbury Park
Bulwinkle, Frederick, Ocean Blvd., Atl. Highlands
Campbell, Wm. K., 96 3rd av., Long Branch
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Cassidy, S. H., Osborn st., Keyport

Clayton, John C., 73 W. Main st., Freehold
DePons, S. R., 501 Grand av., Red Bank
Dewis, Edwin G., 1018 Fourth av., Asbury Park
Donovan, William F., Brielle
Edelson, Samuel, 1141 Corlies av., Neptune
Ellenson, S. S., 507 4th av., Asbury Park
Fairbanks Warren H., 27 Broadway, Freehold
Featherston, Daniel F., 506 4th av., Asbury Park
Feinberg, Harry D., 384 2d av., Long Branch
Fenton, Tennent E., 320 Ludlow av., Spring Lake
Fisher, James A., 501 Grand av., Asbury Park
Friedman, H. H., 63 W. Main st., Freehold
Gesswein, Carl A., Church st., Keyport
Goff, Frank J., 64 Maple av., Red Bank
Gordon, J. B., N. J. State Hospital, Marlboro
Gosling, W. W., 23 Monmouth av., Red Bank
Graves, Charles, State Hospital, Marboro
Guilium, W. H., 505 Fourth av., Asbury Park
Haines Emerson S., 501 Grand av., Asbury Park
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, William, 23 Monmouth st., Red Bank
Herrman, Wm. G., 501 Grand av., Asbury Park
Hill, J. A., 511 Cedar av., Allenhurst
Holman, Francis W., 133 Broad st., Keyport
Holters, Otto R., 513 2d av., Asbury Park
Hunt, Geo. Halsey, 129 Broad st., Red Bank
Hyer, Oscar H., 210 Main st., Matawan
Ingling, Harry W., 51 W. Main st., Freehold
Jamison, W. F., 501 Grand av., Asbury Park
Jones, Granville L., N. J. State Hospital, Marlboro
Jordan, J. C., 238 E. Main st., Manasquan
Kazmann, Harold A., 406 Broadway, Long Branch
Knapp, Victor, 1005 Grand av., Asbury Park
Krohn, Marc, Church Blvd., Keansburg
Leighton, Robt. L., 401 Ludlow av., Spring Lake
Leonard, Lothair L., 615 Asbury av., Asbury Park
Lorenzo, M. J., 64a Bridge av., Red Bank
Lovett, Irving K., 100 E. Front st., Red Bank
MacKenzie, R. A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Mason, Howard B., 90 W. Main st., Freehold
Mathews, William, 65 Broad st., Red Bank
Moffatt, Barclay W., Nut Swamp rd., Red Bank
Neiderhoffer, S. L., 469 B'way, Long Bronch
Nichols, Stanley H., 501 Grand av., Asbury Park
Niemtzow, Frank, 45 E. Main st., Freehold
Opfermann, J. L., 167 Bay av., Highlands
Parker, James W., 175 Shrewsbury av., Red Bank
Parry, O. K., 601 Bangs av., Asbury Park
Perrine, C. C., 500 River rd., Fair Haven
Pieper, Howard C., 575 Cedar av., W. Long Branch
Podell, Alfred, 51 E. Front st., Red Bank
Pons, C. A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Prout, Charles, 406 6th av., Asbury Park
Quirk, Martin A., 104 Maple av., Red Bank
Reynolds, G. G., 64 W. Main st., Freehold
Robinson, E. A., 149 Atkins av., Asbury Park
Robinson, William A., 62 Main av., Ocean Grove
Rosenthal, A., 38 Mount st., Atlantic Highlands
Rowland, James J., 321 Bay av., Highlands
Rubin, A. David, 401 1st av., Asbury Park
Rullman, Walter, 58 W. Front st., Red Bank
Sands, O. L., 90 W. Front st., Red Bank
Sayre, William D., 69 Maple av., Red Bank
Schmidt, Albert F., 81 Union av., Manasquan
Scott, E. A., Belle Mead San., Belle Mead
Sewell, Stephen, 212 Jersey av., Spring Lake
Slocum, Harry B., Bath av., Long Branch
Stevenson, Geo. S., W. Front st., Red Bank
Strahan, F. G., 473 Broadway, Long Branch
Straughn, C. C., 23 Monmouth st., Red Bank
Strauss, Arthur, 130 Pavil. av., Long Branch
Toren, Julius, State Hospital, Marlboro
Traverso, Daniel, 705 D st., Belmar
Trippe, C. M., 702 Asbury av., Asbury Park
Upham, Helen T., 305 Third av., Asbury Park
Vaccaro, S. P., 511 Third av., Asbury Park
Villapiano, Jos. G., 706 Sixth av., Asbury Park
Wallin, Alfred C., 195 Main st., Matawan
Watkins, Robert E., 517 5th av. Belmar
Wiener, Joseph, 601 Bangs av., Asbury Park
Wilbur, Franklin L., 504 Asbury av., Asbury Park
*Wilbur, G. F., 502 Asbury av., Asbury Park
Wilson, R. B., 91 Broad st., Red Bank
Wise, Lester D., 119 Morris av., Long Branch
Woronoff, Murray, 120 Main st., Keyport

Honorary Members

Grossman, M., 601 Bangs av., Asbury Park
Havens, W. P., Farmingdale
Pietri, R. 501 Grand av., Asbury Park
Ranshoff, N., Brighton av., Long Branch

Number of active members and basis of representation, 107.

100 per cent paid up March 1, 1935.

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

President, McMahon, Bernard C., Morristown

Vice-President, Costello, William F., Dover

Secretary, Ward, Albert J., Morristown

Treasurer, Young, George J., Morristown

Reporter, Curry, Marcus A., Greystone Park

*Historian, Kice, H. W., Wharton

Executive Committee, The Officers and
Frost, I. F., Morristown
Pinckney, F. H., Morristown
Larson, H. M., Morristown

Active Members

Abell, Elvira Dean, Morristown
Baker, Augustus L., 389 W. Blackwell av., Dover
Beaver, Jennie Dean, 8 Oliphant Park, Morristown
Bird, Frank L., Netcong
Booth, Wm. K., Boonton
Byrne, James A., Morristown
Carberry, Edw. T., Wharton
Chilton, F. S., Pompton Plains
Collins, Lawrence M., Greystone Park
Comeau, G., Morris Plains
Costello, William Francis, Dover
Coultas, A. B., Madison

Curry, Marcus A., Greystone Park
Diechman, C., Morristown
Donovan, J., Greystone Park
Eckhardt, Ralph A., Madison
Emory, George B., 1 Franklin pl., Morristown
Falvello, N. A., Morristown
Ferriss, Ruth, Morristown
Frost, I. F., Morristown
Galasso, Attilio, 1 Cutler st., Morristown
Geary, Daniel J., Morristown
Gibb, W. Blake, Morristown
Gilbertson, R. L., Madison
Glazebrook, F. H., Morristown
Gordon, Charles D., Mt. Arlington
Gregory, Marie F., Green Village rd., Madison
Harrington, J. Henry, Rockaway
Hatch, H. S., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Heinig, Frank G., Boonton
Hubert, Antonio, 133 Main st., Rockaway
Johnston, Julian F., Chatham
King, Alden P., Dover
Kossman, W. J., Long Valley
Krauss, Fletcher I., Chatham
Kuite, George B., Morris Plains
Lane, A. G., Greystone Park
Larson, Henry M., 36 Franklin st., Morristown
McElroy, Ervin, Rockaway
Mathews, R., Morristown
Mial, Leonidas L., 38 Elm st., Morristown
Michell, George, 221 High st., Hackettstown
Miller, T. B., Butler
Mills, Clifford, Morristown
Musetto, Carmelo A., Boonton
Pinckney, Frank H., Morristown
Plume, Clarence A., Succasunna
Pottinger, W., Mountain Lakes
Reed, F. Grendon, Denville
Schmidt, H. R., Lincoln Park
Schmitz, Mathias, Denville
Schulman, R., Morristown
Scott, Harold R., Morristown
Spencer, A., Dover
Stage, Earl DeW., Morristown
Talmage, Wm. G., Succasunna
Teskey, S., Bernardsville
Thomas, T. S., Morristown
Truax, Alfred J., Boonton
Van Sickle, Albert W., Chester
Voorhies, W. S., Mendham
Ward, Albert J., 39 Elm st., Morristown
Washburn, Philip C., Greystone Park
Williams, Louis E., Madison
Young, George J., 23 Franklin pl., Morristown

Honorary Members

*Kice. H. W., Wharton
van Beuren, Frederick T., Morristown

Number of active members and basis of representation, 67.

March 1, 1935

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month, October to May inclusive. Annual Meeting in November.

President, Woodhouse, Alfred, Toms River

Vice-President, Beurmann, Robert, Lakewood

Secretary, Hayden, W. G., Toms River

Treasurer, Brouwer, Frank, To ns River

Reporter, Goldstein, Abraham, Lakewood

Censors, Disbrow, Harold, Lakewood
Towbin, Harold, Lakewood
Bunnell, Fred, Barnegat
Willis, Herbert

Active Members

Brouwer, Frank, Toms River
Buermann, Robert, Lakewood
Bunnell, Frederick N., Barnegat
Carmona, Louis R., Tuckerton
Disbrow, Harold B., Lakewood
Disbrow, Vanderhoof M., Lakewood
Dodd, Wm. E., Beach Haven
Goldstein, A., Lakewood
Halbach, Robert, 513 Main st., Toms River
Hayden, W. G., 412 Main st., Toms River
Hendrickson, Bruce, Point Pleasant
Herbener, E. G., Lakewood
Ivory, Harry, Point Pleasant
Lemacher, Frank, Lakewood
Obert, J. E., New Egypt
Sickel, E. M., Lakewood
Swan, Guy H., Beachwood
Thomson, T. F., Lakewood
Towbin, Adolph, Lakewood

Honorary Members

Jones, R. R., Toms River

Number of active members and basis of representation, 19.

100 per cent paid up March 1, 1935.

PASSAIC COUNTY (16)

Society organized January 14, 1844. Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

President, MacMillan, Wright, Passaic

First Vice-President, Dingman, Norman, Paterson

Second Vice-President, Vosburg, Fred, Passaic

Secretary, Hall, Wayne W., Paterson

Treasurer, Leonard, E. A. Paterson

Reporter, Johnsen, S. W., Passaic

Censors, Bergin, Joseph V., Paterson
Roemer, Jacob, Paterson
Willard, Harry S., Paterson

Active Members

Allen, J. M., 657 Main av., Passaic
Armstrong, Robt. R., 114 Pennington av., Passaic
Ash, Frank W., 108 Carroll st., Paterson
Atkinson, Jas. W., 485 S. Maple av., Glen Rock
Barlow, Frank A., 91 Lafayette av., Passaic
Barr., Joseph, 975 Madison av., Paterson
Becker, Leo V., 69 Ward st., Paterson
Bender, Theo. T., 666 Broadway, Paterson
Bergin, J. V., 315 Broadway, Paterson
Beshlian, Hagop K., 7 Lee pl., Paterson
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bonynge, Henry A., 123 Prospect st., Ridgewood
Botbyl, B. W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brancato, Peter, 17 Church st., Paterson
Bromberg, Chas. B., 107 Lexington av., Passaic
Brooks, S. S., 62 12th av., Paterson
Butterfield, Arey A., Pas. Nat. Bk. Bldg., Passaic
Cantrell, W. C., 88 Union st., Clifton
Carlisle, John H., 129 Prospect st., Passaic
Carlough, D. J., 426 Ellison st., Paterson
Catanzaro, F., 151 Jefferson st., Passaic
Chase, W. E., 587 Main st., Passaic
Chester, Saul W., 264 Graham av., Paterson
Chrisman, Irving, 408 Ellison st., Paterson
Clay, Thomas A., 351 Totowa av., Paterson
Cogan, Henry, 128 Carroll st., Paterson
Cole, L. Frank, 242 Broadway, Paterson
Colfax, Wm. S., 33 Bartholf av., Pompton Lakes
Connolly, T. Vincent, 54 Hamilton st., Paterson
Coppela, Edward A., 447 Lexington av., Clifton
Cremens, John F., 144 Carroll st., Paterson
Crounse, D., 84 Broadway, Passaic
Dawson, Harry E., 618 24th st., Paterson
Delario, A. J., 56 Cross st., Paterson
De Mattia, Michael, 71 Cedar st., Paterson
Denton, Peter P., 951 Madison av., Paterson
De Rosa, Armond, 290 Union Blvd., Paterson
De Rosa, John, 150 Fair st., Paterson
De Yoe, Leon E., 602 Broadway, Paterson
Dingman, N. M., 330 Broadway, Paterson
Drake, Daniel E., Greenw'd Lake rd, Newf'ndland
Dunning, Walter L., 533 River st., Paterson
Durant, H. J., 661 E. 23rd st., Paterson
Dwyer, Henry E., 261 Madison av., Passaic
Dwyer, William A., 99 Park av., Paterson
Edekrant, Walter L., 82 President st., Passaic
Ehrenfald, Edward, 116 Lexington av., Passaic
Ekings, Frank P., Paterson
Feigenoff, Israel, 420 Broadway, Paterson
Fisher, Samuel, 808 Madison av., Paterson
Flitcroft, William, 510 River st., Paterson
Gallo, James F., Haledon
Gallo, James S., 32 Zabriske st., Haledon
Giambra, S. M., 666 Broadway, Paterson
Gillson, Hugh V., 21 Lee pl., Paterson
Gillson, John T., 170 Broadway, Paterson
Ginsberg, Samuel, 136 Broadway, Passaic
Glasgow, Thomas, 120 Passaic av., Passaic
Gochman, Henry M., 166 Hamilton av., Paterson
Golding, Harry N., 180 Carroll st., Paterson
Gordon, A., 616 Main av., Passaic
Gordon, Osher, 119 Lexington av., Passaic
Graham, A. F., 42 Park av., Paterson
Graham, Theodore K., 278 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Hagen, Orville R., 266 Van Houten st., Paterson
Hall, W. W., 266 Van Houten st., Paterson
Hambright, A. M., Paterson
Harreys, Chas. W., 714 Broadway, Paterson
Holmes, F. J. E., 151 Fair st., Paterson
Holt, Herman Harold, 285 Graham av., Paterson
Irving, Albert, Albert Court, Radburn
Ives, Edward I., 24 Stevens av., Little Falls
Jacob, William H., 99 N. Main av., Paterson
Jahn, Albert, Passaic National Bank, Radburn
Jani, Frank, 297 Lexington av., Passaic
Jarmulowsky, Harry, 237 Broadway, Paterson
Joelson, Morris S., 577 Broadway, Paterson
Johnsen, S. W., 49 Passaic av., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Kane, Charles J., 349 Grand st., Paterson
Keating, C. A., 177 Ellison st., Paterson
Keller, F. J., 795 Broadway, Paterson
Keppler, Charles, Jr., 723 Allwood rd, Clifton
Kim, Gay Bong, 528 Totowa rd., Totowa
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Kroll,, Adolph, Jr., 103 Van Buren st., Passaic
Kuhl, John P., High st., Butler
Laauwe, H. W., 198 Haledon av., Paterson
Labash, Charles, 83 Quincy st., Passaic
Landaw, Louis, 583 Broadway, Paterson
Lawrence, Elias D., Paterson
Leonard, E. A., 771 Madison av., Paterson
Levendusky, D. E., 52 Market st., Passaic
Levine, D. B., 647 Broadway, Paterson
Levine, Sidney C., 459 Park av. & 30th st., Pat'son
Levinsohn, S. A., 584 Broadway, Paterson
Linares, A. C., 208 Market st., Paterson
Lomauro, Jas. R., 73 Gron st., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucas, Henry H., 266 Van Houten st., Paterson
Lucent, S. Bell, 48 Main st., Little Falls
MacAlister, Wm. W., 333 Van Houten st., Paters'n
MacMillan, Wright, 23 Passaic av., Passaic
McBride, Andrew F., 30 Church st., Paterson
McCamey, Kenneth E., 174 Carroll st., Paterson
McCoy, John C., 292 Broadway, Paterson
McDede, Frank F., 922 Main st., Paterson
McDonald, R. J., 294 Broadway, Paterson
McPherson, M. E., 171 Diamond Bdg av., Hawth'e
Maclay, Joseph A., 181 E. 33rd st., Paterson
Magennis, Bryan C., 170 Hamilton av., Paterson
Maloney, L. F., 156 2nd st., Clifton
Manley, Thos. E., 390 Park av., Paterson
Maps, Howard L., 53 Passaic av., Passaic
Marini, D., 40 Henry st., Passaic
Markowitz, Louis, 16 Church st., Paterson
Marrocco, Wm., 261 Park av., Paterson
Marsh, Elias J., 400 Van Houten st., Paterson
Masucci, A., 34 Ward st., Paterson
Meloney, Lester F., 156 2nd st., Clifton
Mendelsohn, D. H., 576 Broadway, Paterson
Meneve, A., 87 Bridge st., Paterson
Meyers, F. R., 326 Park av., Paterson

Mills, Alvah V., Lindsley rd., Little Falls
Missonellie, Wm., 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Morrill, James P., 310 Broadway, Paterson
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 245 Broadway, Paterson
Nesbit, Elizabeth, N. J. Tr'n'g School, Little Falls
Notkin, Meyer, 351 Van Houten st., Paterson
Nye, Howard H., 174 Broadway, Paterson
O'Brian, D M., 162 Lexington av., Passaic
Okin, I., 23 Passaic av., Passaic
Oram, Joseph H., 495 Broadway, Paterson
Pal, D. R., 32 Clark st., Paterson
Palmer, Francis R., 27 Monroe st., Passaic
Park, M. B., 360 Park av., Paterson
Payawall, J. L., 170 Broadway, Paterson
Pelusio, August N., 269 Carroll st., Paterson
Phephs, J. E., 203 Park av., Paterson
Plinke, Fritz, 159 Lexington av., Passaic
Polowe, David, 558 E. 27th st., Paterson
Prince, Robert A., 272 Park av., Paterson
Reading, H. E., 538 E. 29th st., Paterson
Reeves, E., 195 Lexington av., Passaic
Reynolds, Earl C., 657 Main av., Passaic
Reynolds, Harry C., 657 Main av., Passaic
Roemer, Jacob, 213 Broadway, Paterson
Roy, Jos. N., 95 17th av., Paterson
Russell, Chas. B., 119 Hamilton av., Paterson
Ryan, John N., 158 Lexington av., Passaic
Sanfacon, Thomas A., 81 Park av., Paterson
Schultz, A. M., 379 Union av., Paterson
Scielzo, N. F., 777 Madison av., Paterson
Scribner, Charles H., Hamburg Tyke, Paterson
Shapiro, L. G., 375 Broadway, Paterson
Shippee, David M., Midvale
Sieveke, J., 106 Lexington av., Passaic
Simon, Morris L., 174 Washington pl., Passaic
Slaff, F., 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
Smith, E. W., 657 Main av., Passaic
Smith, Leon A., 72 Grove st., Passaic
Spickers, William, 6 Church st., Paterson
Stein, Harry M., 227 W. Broadway, Paterson
Steinberg, Benj. Louis, Four Corners, Singac
Stinson, Richard, 641 E. 18th st., Paterson
Stolz, R. R., 23 Passaic av., Passaic
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, Wm. M., 43 Passaic av., Passaic
Surnamer, Isaac, 345 Broadway, Paterson
Sutherland, W. W., 320 Broadway, Paterson
Tellman, D. H., 120 Lexington av., Passaic
Temple, Arthur H., 164 Jefferson st., Passaic
Terhune, Percy H., 171 Paulison av., Passaic
Thorne, Wm. P., 30 Main st., Butler
Todd, Francis H., 83 Auburn st., Paterson
Tomkins, Wm., Hohokus
Tuers, George E., 418 Park av., Paterson
Tweddel, George K., 239 Broadway, Paterson
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vander Clock, C., 23 Passaic av., Passaic
Van Riper, A. Ward, 605 Main av., Passaic
Van Schott, G. J., Jr., 245 Lexington av., Passaic
Van Urk, Frederick T., 210 Lexington av., Passaic
Vosburg, Fred, 125 Prospect st., Passaic
Vreeland, Ralph J., 266 Van Houten st., Paterson
Walker, Harold G., Everett av., Wyckoff
Walton, Gordon G., 17 Church st., Paterson
Warburton, Jack C., 277 Broadway, Paterson
Warren, D. E., 265 Gregory av., Passaic
Warren, Jacob, 372 E. 35th st., Paterson
Wassing, Hans, 695 Broadway, Paterson
Widetsky, Alfred, 69 Hamilton av., Paterson
Wilkinson, Boyd E., 266 Van Houten st., Paterson
Willard, Harry S., 266 Van Houten st., Paterson
Williams, Hiram, 230 Lexington av., Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnach, Meyer, 318 Broadway, Paterson
Wolfson, H., 324 Broadway, Paterson
Wry, Dean A., 244 Dayton av., Clifton
Yager, Jacob A., 6 Church st., Paterson
Yates, John S., 414 Ellison st., Paterson

Transfers

Wideski, Alfred, to Bergen County Society
Smith, C. D., to Bergen County Society

Number of active members and basis of representation, 208.

March 1, 1935.

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social meeting in May.

President, Perry, Frank L., Woodstown

Vice-President, Fleming, C. L., Pennsgrove

Secretary-Treasurer, Green, D. W., Salem

Reporter, Hummel, L. C., Salem

Censors, Hummel, L. C., Salem
James, W. H., Pennsville
Perry, Frank L., Woodstown
Weigel, C. B., Salem

Active Members

Bramble, Halsey S., Elmer
Davidson, C. Spencer, Pennsgrove
Davis, Richard M. A., Salem
Dunn, John S., Salem
Evans, E. E., Pennsgrove
Fleming, C. L., Pennsgrove
Green, David W., Salem
Hilliard, William T., Salem
Hummel, L. C., Salem
James, William H., Pennsville
Mackes, C. L., Woodstown
Miller, Louis H., Woodstown
Perry, Frank L., Woodstown
Prigger, E. R., Pennsgrove
Summerill, John M., Pennsgrove
Suter, Harry F., Pennsgrove
Weigel, C. B., Salem

Number of active members and basis of representation, 17.

100 per cent paid up March 1, 1935.

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on the second Thursday in February, April, June, October and December. Annual Meeting in October.

President, Hegeman, R. F., Somerville

Vice-President, Gray, William B., Plainfield

Secretary, Sferra, Alfred F. W., Bound Brook

Treasurer, Lawton, A. A., Somerville

Reporter, Young, James L., Somerville

Censors, McConaughy, Francis, Somerville
Meigh, Josiah, Bernardsville
Flynn, T. H., Somerville

Active Members

Adams, Rayford K., Skillman
Albrecht, W. J., Somerville
*Allis, Jere, Basking Ridge
Anderson, John E., Neshanic
Baker, B. S., Skillman
Barbour, Geo. E., Somerville
Beekman, John B., Bedminster
Borow, Benjamin, Bound Brook
Borow, Henry, Bound Brook
Borow, Lewis, Bound Brook
Borow, Maurice Bound Brook
Brittain, Elmer G., Bound Brook
Cook, J., Bound Brook
Cooley, R. L., Dunellen
Cooper, J. Howard, East Millstone
Craig, Henry August, Somerville
Crawford, John W., Bedminster
Dundon, A. H., North Plainfield
Earp, Ruth, Bernardsville
East, J. Cooper, Skillman
Ely, Lancelot, Somerville
Field, Frank L., Far Hills
Flint, Edgar T., Raritan
Flynn, Thomas A., Somerville
Francis, Adaline M., Somerville
Gray, W. B., North Plainfield
Greenberg, George A., Somerville
Halstead, Charles F., Somerville
Hamblin, D. O., Bound Brook
Hegeman, Runkle F., Somerville
Hurd, Emerson F., Bound Brook
Husted, S. H., Neshanic
Kay, Clarence R., Peapack
Knight, Augustus S., Far Hills
Lawton, Anderson A., Somerville
Levy, A., Somerville
Long, William H., Somerville
Lovejoy, J., Bound Brook
Lukats, E. J., Skillman
Massey, J. B., New Brunswick
McConaughy, Francis, Somerville
Meigh, Josiah, Bernardsville
Panigrosso, L. B., Raritan
Pigott, Albert W., Skillman
Pogoloff, Samuel H., Manville
Renner, Dan Smith, Skillman
Robinson, John T., Bound Brook
Scott, Michael, Skillman
Sferra, Alfred F. W., Bound Brook
Sherlock, Margaret E., Vinel'd State Sch'l, Vinel'd
Smalley, Mahlon C., Peapack
Stillwell, Aaron L., Somerville
Wallach, B., North Plainfield
Wild, Frederick A., Bound Brook
Young, James L., Somerville
Zeglio, Peter J., North Plainfield

Honorary Members

All Medical Officials and Medical Staff of the Veterans' Hospital in Millington.

Removed from County

Massey, J. B., Somerville

Transferred

Hamblin, H. O., To Virginia

Number of active members and basis of representation, 55.

100 per cent paid up March 1, 1935.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets bi-monthly, September to May, inclusive. Annual Meeting on the second Tuesday in September.

President, Johnson, George J., Branchville

Vice-President, Scott, F. John, Franklin

Secretary, Wilbur, Frederick P., Franklin

Treasurer, Drake, L. B., Ogdensburg

Reporter, Morrison, Frederick H., Newton

Censors, Coleman, Joseph G., Hamburg
Smith, Warren H., Newton
Voorhees, Lamar, Newton

Active Members

Braun, D. C., Newton
Burn, Victor E., Newton
Cole, Blase, Newton
Coleman, Joseph G., Hamburg
Drake, L. B., Ogdensburg
Groeschel, A. H., Sussex
Jacob, Albert N., Sparta
Johnson, George, Branchville
Landis, Edwin W., Stillwater
McCall, Jesse, Newton
McVeigh, Charles, Stanhope
Morrison, Frederick H., Newton
Pellet, T. L., Hamburg
*Pooley, Thomas R., Jr., Newton
Rothman, B. G., Sussex
Roy, Bert W., Sussex
Scott, F., Franklin
Smith, Warren H., Newton
Spencer, J. H., Jr., Newton
Spurgeon, D. L., Newton
*Uptigrove, E. P., Vernon

Voorhees, Lamar, Newton
Wilbur, Frederick P., Franklin

Honorary Members

Cole, Martin H., Hainesville
Pellett, Jackson B., Hamburg

Number of active members and basis of representation, 21.

100 per cent paid up March 1, 1935.

UNION COUNTY (20)

Society organized June 7, 1859. Meets on the second Wednesday of February, April, October and December. Annual Meeting in October.

President, Krans, Edward S., Plainfield

Vice-President, Walsh, Thomas J., Elizabeth

Secretary, Armstrong, Lorimer B., Westfield

Treasurer, Hoover, Alden R., Elizabeth

Reporter, Shirrefs, Russell A., Elizabeth

Censors, Schlichter, Charles H., Elizabeth
Currie, N. W., Plainfield
Prout, Thos. P., Summit
Reiner, Jacob, Elizabeth
Shangle, Milton, Elizabeth

Active Members

Abel, Henri E., 345 Union av., Elizabeth
Ackerman, Arthur F., 129 Summit av., Summit
Armstrong, L. B., 121 S. Euclid av., Westfield
Arthur, Frances, 138 Westfield av., Elizabeth
Austin, T. R., 16 Alden st., Cranford
Babbitt, Hugh M., Jr., 113 W. 7th st., Plainfield
Baker, Raymond Dewitt, 52 DeFor. av., Summit
Barr, A. H., 830 Wood av., N., Linden
Baruch, Rudolph J., 414 Elizabeth av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 414 Elizabeth av., Elizabeth
Birrell, R. G., 554 Westminster av., Elizabeth
Bishop, Carl, 928 W. 8th st., Plainfield
Blair, T. D., 414 Park av., Plainfield
Bloch, Harry, 200 E. Jersey st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Roland P., 30 Springfield av., Cranford
Boozan, Wm. E., 1139 E. Jersey st., Elizabeth
Bourns, Edward G., 126 Harrison av., Westfield
Bowles, Harry H., 36 Woodland av., Summit
Boyes, J. G., 1326 Chetwynd av., Plainfield
Brokaw, Chris. A., 1405 North av., Elizabeth
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown ,William H., 29 3rd st., Elizabeth
Bunting, P. DuBois, 712 N. Broad st., Elizabeth
Burritt, Norman W., 30 Beachwood rd., Summit
Butenas, Jos. J., 300 1st av., Elizabeth
Byington, R., 261 Springfield av., Summit
Callahan, Edward J., 640 E. Broad st., Westfield
Canright, C. M., 2 Berkley pl., Cranford
Cantini, Raphael, 924 Plainfield av., Plainfield
Card, Charles F., 100 W. Milton av., Rahway
Carlin, Edward J., 20 Jacques av., Rahway
Carpenter, C. C., 129 Summit av., Summit
Casilli, A. R., 618 Newark av., Elizabeth
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth
Chapman, O. P., 125 Broad st., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Cole, Walter H., Jr., 116 Chilton st., Elizabeth
Communale, A. R., 63 Irving st., Rahway
Corbusier, H. D., 612 Park av., Plainfield
Crabtree, Loren H., 142 Bellevue st., Elizabeth
Cregar, Peter B., 420 Grant av., Plainfield
Cronin, Francis J., 730 South st., Elizabeth
Currie, Norman W., 508 Central av., Plainfield
Davidson, E. Norwell, 102 Elm st., Linden
Davidson, M. M., 128 Grand av., E., Roselle Park
Davis, F. C., 129 Summit av., Summit
Davis, Stanton H., 212 E. 7th st., Plainfield
Day, Willis B., 154 E. 7th st., Plainfield
DeCesare, F. D., 500 Walnut st., Roselle Park
Decker, Charles T., 178 Elm st., Westfield
DeFreitas, Clement, 423 W. 4th st., Plainfield
Dengler, H. P., Morris av., Springfield
Dennin, Jos. W., 308 Chestnut st., Roselle
Disbrow, G. Ward, 126 Mountain av., Summit
Doggert, E. Hugh, 113 Watchung av., Plainfield
Donnald, E. Cox, 416 West av., N. Linden
Drury, Alfred J., 268 E. 3rd av., Roselle Park
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
Dwoyer Leon C., 801 Wood av., Linden
Eason, S. N., 48 DeForest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Max, 513 Westfield av., Elizabeth
Ferguson, Chas., 435 Westminster av., Elizabeth
Fiedler, M., 1012 E. Jersey st., Elizabeth
Fitch, Thomas, 744 Watchung av., Plainfield
Ford, Theodore R., 19 Prospect st., Summit
Foster, Frank C., 320 Springfield av., Cranford
Franklin, Jos. E., 127 Westfield av., Elizabeth
Friedburg, Geo. H., 1108 Anna st., Elizabeth
Frohwein, Ida H., 119 Morristown rd., Elizabeth
Funk, Joseph, 615 Elizabeth av., Elizabeth
Galloway, George E., 109 Milton av., Rahway
Geary, Paul, 923 Park av., Plainfield
Gerendasy, J., 225 E. Jersey st., Elizabeth
Gibbs, Alice S., 339 Union av., Elizabeth
Giglio, A. S. V., 626 Elizabeth av., Elizabeth
*Gilpin, Friend B., 118 North av. W., Cranford
Gittelman, Morton, 1028 E. Jersey st., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glasston, H. M., 628 N. Wood av., Linden
Golden, William M., 70 Irving st., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldstein, H. H., 1065 E. Jersey st., Elizabeth
Gonczy, Edward J., 25 Elm st., Elizabeth
Goodrich, S. L., 466 Highland av., Orange
Gorczyca, A. G., 538 S. Broad st., Elizabeth
Green, James S., 463 N. Broad st., Elizabeth
Gregory, R. A., 121 E. 7th St., Plainfield
Griesmier, Zadoc L., 1143 E. Jersey st., Elizabeth
Guidl, Guido M., 212 Christine st., Elizabeth
Hallock, W. J., Berkeley Height, Summit
Hanrahan, Jas. N., 114 E. Broad st., Elizabeth
Harrison, Joseph B., 302 E. Broad st., Westfield
Haseltine, S. L., Hersch Bldg., Elizabeth
Herrington, Lee R., 147 Cental av., Westfield
Hipple, Percy L., Jr., 225 Walnut st., Roselle
Hnat, Frederick, 417 Madison av., Elizabeth
Hoffman, C. A., 302 E. 7th st., Plainfield
Holland, Ruben J., Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holtzman, Michael, 167 2nd st., Elizabeth
Hoover, A. R., 5 Prince st., Elizabeth
Horre, Geo. W. H., 203 W. Jersey st., Elizabeth
Hubbard, Harry H. V., 121 E. 7th st., Plainfield

Hughes, Frederick J., 706 Park av., Plainfield
Hutton, F. T., 161 Crescent av., Plainfield
Imbleau, J. E. L., 2106 Morris av., Unionville
Iserman, Michael, 376 Elmora av., Elizabeth
Johnson, Harold F., 734 Park av., Plainfield
Jones, Lewis H., 139 Grant av. E., Roselle Park
Kapp, Carl G., 410 Westminster av., Elizabeth
Keeney, C. B., 137 Summit av., Summit
Kinch, F. A., 267 E. Broad st., Westfield
Knauer, George, 930 Elizabeth av., Elizabeth
Knepper, Orcena F., 149 Crescent av., Plainfield
Konzelman, Henry J., 50 King st., Hillside
Krans, Clara M. De H., 920 Park av., Plainfield
Krans, Edw. S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kushner, Alexander, 48 Jacques av., Rahway
Labow, Joseph T., 1063 E. Jersey st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Laird, George S., 127 Central av., Westfield
Lance, E. W., 93 W. Milton av., Rahway
Larrabee, C. H., 30 Beechwood rd., Summit
Lathrop, Frederick W., 507 Park av., Plainfield
Laurie, Andrew L., 664 Newark av., Elizabeth
Lawrence, Wm. H., Jr., 129 Summit av., Summit
Leggett, Thos. H., Jr., 937 Oakland pl., Plainfield
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 1072 North av., Elizabeth
Lieberman, Milton L., 101 Union av., Roselle Park
Lilien, M. M., 162 Gruman av., Hillside
Linke, Julian P., 245 E. Front st., Plainfield
Livengood, Horace R., 587 Westminster av., Eliz.
Losada, Camella A., 19 Prospect st., Summit
Lowell, M. E., 434 Summit av., Westfield
Luffburrow, C. B., 441 W. Front st., Plainfield
Lyerly, J. M., 1116 Putman av., Plainfield
Lynch, Edward Thos., 748 Livingston rd., Eliz.
Maggio, Ross J., 200 Ross pl., Westfield
Malatesta, C. S., 741 Kingston av., Plainfield
McCallion, W. H., 722 Westminster av., Elizabeth
McClintoch, Elsie, 1435 Maple av., Hillside
McElhinney, Dennis R., 110 W. Jer. st., Elizabeth
McGinn, W. J., Westfield av., Fanwood
Merlo, Francis A., 500 E. Jersey st., Elizabeth
Miller, Robt. M., 382 Springfield av., Summit
Mills, Stephen D., 132 S. Euclid av., Westfield
Minnella, Thos. J., 12 Russell pl., Summit
Moister, Roger W., 30 Beachwood rd., Summit
Montfort, Robt. J., 1051 E. Jersey st., Elizabeth
Moress, Edward J., 1501 Maple av., Hillside
Morris, Thos. M., 503 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
*Mravlag, Victor, 1064 E. Jersey st., Elizabeth
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Newman, Louis G., 316 E. Broad st., Westfield
Nittoli, R. N., 660 E. Jersey st., Elizabeth
Obester, G. E., 617 Madison av., Elizabeth
O'Brion, D. J., 197 Spring st., Portland, Maine
Orton, Carlton B., 235 Chestnut st., Roselle
Orton, George Lee, 98 Elm av., Rahway
Paulson, Arch'd M., 160 E. 7th st., Plainfield
Peal, Sidney S., 815 Kilsyth rd., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, W. F., 124 Chilton st., Elizabeth
Proudfoot, P. A., 220 Chestnut st., Roselle
Prout, Thos. P., 19 Prospect st., Summit
Quinn, Stephen T., 326 S. Broad st., Elizabeth
Radding, M. B., 321 Elmora av., Elizabeth
Randolph, John M., 131 Main st., Rahway
Rathbone, T. J., 129 Summit av., Summit
Read, Jessie D., 619 Elm st., Westfield
Reich, Jerome J., 1420 Maple av., Hillside
Reiner, Jacob, 811 N. Broad st., Elizabeth
Robertson, Grace M., 650 W. 7th st., Plainfield
Rose, Abraham B., 212 S. Broad st., Elizabeth
Runnells, J. E., Scotch Plains
Sacco, Gregory E., 567 Colonial av., Westfield
Sadoff, Joseph, 116 Elmora av., Elizabeth
Salvati, Leo H., 224 Walnut st., Westfield
Samuels, S. Lawrence, 612 W. Front st., Plainfield
Schenk, Jos. R., 1177 Park av., Plainfield
Schilling, A. B., 727 Jefferson av., Elizabeth
Schlichter, Chas. H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 414 Park av., Plainfield
Schweitzer, Roman G., 860 E. Jersey st., Elizabeth
Sell, Frederick W., 113 Commerce st., Rahway
Seybold, Arthur D., 302 E. 7th st., Plainfield
Seymour, Geo. A., 253 Orchard st., Elizabeth
Shangle, Milt A., 34 Prince st., Elizabeth
Sherman, Samuel H., 81 Elmore av., Elizabeth
Shirrefs, Russell A., 55 Broad st., Elizabeth
Sly, John L., 382 Springfield av., Summit
Spivack, David 943 E. Jersey st., Elizabeth
Stanton, Nath. B., 734 Park av., Plainfield
Staubb, E. Milton, 531 E. Broad st., Westfield
Steele, Stephen, 500 Wood av., Linden
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., 411 Westminster av., Elizabeth
Stein, Isadore, 210 Elizabeth av., Elizabeth
Stein, Martin H., 163 Second st., Elizabeth
Stephenson, G. A., 145 Summit av., Summit
Stern, Arthur, 224 E. Jersey st., Elizabeth
Steuart, David F. R., 10 De Barry pl., Summit
Stillwell, Harry C., 65 W. Milton av., Rahway
Strelinger, Alexander, 689 Newark av., Elizabeth
Strom, A., 410 W. 7th st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Thomas, Mary L., Village for Epileptics, Skillman
Tidaback, John D., 447 Springfield av., Summit
Turner, Wm. F., 519 Magle st., Elizabeth
Tyndall, Alice E., 519 E. Broad st., Westfield
Tyndall, Martha W., 519 E. Broad st., Westfield
Vail, Jas. Lindley, 28 Holly st., Cranford
Van Horn, Alfred F., 514 Central av., Plainfield
Vinclguerra, Michael, 410 Westminster av., Eliz.
Vitale, Domlnic V., 681 Newark av., Elizabeth
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Wacker, William F., 42 Hollywood av., Hillside
Wade, Simon F., 555 Newark av., Elizabeth
Wagner, Otto, 111 Stiles av., Elizabeth
Walsh, Ronald J., 118 E. 5th av., Roselle
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Walters, Geo. M., 648 E. Broad st., Westfield
Ward, Leo J., 137 W. Jersey st., Elizabeth
Warncke, F. H., 523 Westfield av., Elizabeth
Wegryn, Louis S., 254 First av., Elizabeth
Weigel, Edgar Wm., 970 Park avv., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Western. Fred'k B., 932 Salem rd., Townley
White, Harry J., Bonnie Burn San., Scotch Plains
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, L. D., 518 Park av., Plainfield
Wolgin, Philip A., 445 Elmora av., Elizabeth
Wood, Fiske, 115 Central av., Westfield
Woody, McIver, 458 Union av., Elizabeth
Yood, Raphael, 401 Grant av., Plainfield
Young, Franklin C., 120 Summit av., Summit
Yuckman, Robert O., 224 W. Jersey st., Elizabeth
Yuckman, William, 224 W. Jersey st., Elizabeth
Zeitlin, H. H., 943 N. Wood st., Linden
Zingales, J. A., 101 Holly st., Elizabeth

Honorary Members

Ard, Frank C., Plainfield

Number of active members and basis of representation, 249.

100 per cent paid up March 1, 1935.

*Deceased.

Received on Transfer

Davidson, M. M.
Orton, C. B.
Stillwell, H. C.
Read, Jessie D.
Vitale, Dominic
Walters, G. M.
Western, F. B.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on the third Tuesday of January, April, July and October; the last named being the Annual Meeting.

President, Baldauf, Herman, Belvidere

Vice-President, Varney, William H., Washington

Secretary, Skinner, William F., Washington

Treasurer, Cummins, G. Wyckoff, Belvidere

Reporter, Bossard H., Phillipsburg

Censors, Bossard, H. B., Phillipsburg
Curtis, F. W., Stewartville
Lyon, C. H., Phillipsburg

Active Members

Albertson, W. C. Belvidere
Allen, William C., Blairstown
Baldauf, Herman, Belvidere
Bloom, Lawrence H., 8 Market st., Phillipsburg
Bossard, Henry B., Phillipsburg
Brasefield, Edgar N., Phillipsburg
Cummins, G. Wyckoff, Belvidere
Curtis, Frank W., Stewartsville
Drake, Paul F., Phillipsburg
Gordon, F. S., Blairstown
Hackett, Leon W., Washington
Hoagland, Louis B., Oxford
Jackson, D. P. D., Belvidere
Krauss, Emory, Phillipsburg
La Riew, Fred J., Washington
Lyon, C. H., Phillipsburg
McMurtrie, William A., Hackettstown
Pursell, William Dana, Phillipsburg
Shimer, Floyd A., Phillipsburg
Skinner, William F., Washington
Smith, J. Meredith, Hackettstown
Spillane, T. H., Phillipsburg
*Tunison, G. O., Oxford
Vail, Wm. Penn, Blairstown
Varney, W. H., Washington
Weres, James, Alpha
West, G. F., Phillipsburg
West, H. R., Phillipsburg
Wing, Raymond, Blairstown
Zuck, A. C., Washington

Number of active members and basis of representation, 29.

100 per cent paid up March 1, 1935.

SUMMARY

Active Members

ATLANTIC	116
BERGEN	223
BURLINGTON	53
CAMDEN	152
CAPE MAY	22
CUMBERLAND	51
ESSEX	747
GLOUCESTER	39
HUDSON	377
HUNTERDON	21
MERCER	178
MIDDLESEX	119
MONMOUTH	107
MORRIS	67
OCEAN	19
PASSAIC	209
SALEM	17
SOMERSET	55
SUSSEX	21
UNION	249
WARREN	29
	2871

The State Society carries no delinquent members. Those County Societies reporting as many members as were paid up last year are carried in this 100 per cent paid up column.

	Associate Members
ATLANTIC	9
BERGEN	
CAMDEN	
CAPE MAY	
CUMBERLAND	
ESSEX	71
GLOUCESTER	
HUNTERDON	55
MERCER	26
MIDDLESEX	23
MONMOUTH	
MORRIS	
OCEAN	
SALEM	
SOMERSET	
SUSSEX, UNION, WARREN	
	184

Deaths during the year, 29.

Number of Associate Members in all Component Societies, 184.

Gain in new members	149	Number on Official List March 15, 1934	2757
Gain in Associate Members	75	Number on Official List April 1, 1935	3055

J. B. MORRISON, M.D.,
Secretary.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in December.

Bergen County.—Meets on second Tuesday each month, except July and August. Annual Meeting in January.

Burlington County.—Meets second Thursday evening of each month. Annual meeting in November.

Camden County.—Meets first Tuesday in each month October to May inclusive, with an outing in June. Annual Meeting in October.

Cape May County.—Meets on first Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets on the second Tuesday of January, April, July and October. Annual Meeting in October.

Essex County.—Annual Meeting is the second Thursday in October. Other meetings on the second Thursday of each month, November to May, inclusive, on call of the Council.

Gloucester County.—Regular meetings on the third Thursday of each month, except June, July and August. Annual Meeting in November. Annual Social Session in October.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, the meeting is held on the next day. Annual Meeting in October.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8.30 p. m., in the Carteret Club at Trenton. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on the third Wednesday of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the fourth Wednesday in each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

Morris County.—Meets on the third Thursday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

Ocean County.—Meets second Wednesday each month except June, July, August and September. Annual Meeting in November.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social Meeting in May.

Somerset County.—Meets on the second Thursday evening in February, April, June, October and December. Annual Meeting in October.

Sussex County.—Annual Meeting on the second Tuesday in September; other meetings bi-monthly, September to May inclusive.

Union County.—Meets second Wednesday of February, April, October and December. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October; the last named being the Annual Meeting.

DATES OF ORGANIZATION OF THE COUNTY MEDICAL SOCIETIES

Somerset—May 21, 1816
Essex—June 4, 1816
Middlesex—June 11, 1816
Morris—June 11, 1816
Cumberland—June 16, 1816
Monmouth—July 24, 1816
Gloucester—Dec., 1818
Hunterdon—June 12, 1821
Warren—Feb. 15, 1826
Burlington—May 19, 1829
Passaic—Jan. 14, 1844
Mercer—May 23, 1848
Camden—Aug. 14, 1846
Hudson—Oct. 11, 1851
Bergen—Feb. 28, 1854
Union—June 7, 1869
Salem—May 4, 1880
Atlantic—June 7, 1880
Cape May—Dec. 18, 1883
Sussex—Aug. 22, 1829
Ocean—Oct. 28, 1903

An Alphabetical List of the Members of the Medical Society of New Jersey

Compiled March 1935

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.
*Deceased.

ACTIVE MEMBERS

Abel, Arthur R., 144 Harrison st., East Orange (7)
Abel, Henri E., 345 Union av., Elizabeth (20)
Abell, Elvira Dean, Morristown (14)
Abey, W. J. H., 23 N. Delaware av., Pennington(11)
Abrams, A. B., 668 Clinton av., Newark (7)
Ackerman, Arthur F., 129 Summit av., Summit(20)
Ackerman, J. F., 1010 Grand av., Asbury Pk. (13)
Ackerman, Joseph, 404 Asbury av., Asbury Pk.(13)
Ackley, David B., 21 N. Clinton av., Trenton (11)
Adams, Chas. F., 34 W. State st., Trenton (11)
*Adams, Flora, Hackensack (2)
Adams, John K., 3 Prospect st., East Orange (7)
Adams, Rayford K., Skillman (18)
Adams, Samuel, 29 Highland av., Jersey City (9)
Adelman, Benj. B., 190 Clinton av., Newark (7)
Adler, Joseph, 933 Ave. C, Bayonne (9)
Africano, J. V., 4246 Hudson Blvd., Union City (9)
Agnew, Hobart M., 27 S. Fullerton av., M'tclair (7)
Ainsley, H. Bryson, 246 Union st., Jersey City (9)
Albano, Joseph, 535 N. 7th st., Newark (7)
Albertson, W. C., Belvidere (21)
Albrecht, W. J., Somerville (18)
Albright, L. F., 118 Madison av., Spring Lake(13)
Alexander, Hugo, 928 Hudson st., Hoboken (9)
Alexander, Samuel, Park Ridge (2)
Alexander, Wallace G., 48 Webster pl., Orange (7)
Alford, Ralph I., 9 N. Mountain av., Montclair (7)
Allan, James S., 49 Prospect st., East Orange (7)
Allen, G. Herbert, 181 Roseville av., Newark (7)
Allen, Isaac L., 521 Palisade av., Union City (9)
Allen, J. M., 657 Main av., Passaic (16)
Allen, William C., Blairstown (21)
Alling, Frederick A., 15 Washington st., Nwk (7)
*Allis, Jere, Basking Ridge (18)
Allman, David B., 104 St. Charles pl., Atl. City (1)
Alpert, Edward, 661 Jersey av., Jersey City (9)
Alter, Nich. M., 410 Fairmount av., JerseyCity(9)
Altman, Charles D., 301 Highland av., Newark (7)
Altschul, F. Jos., 177 Garfield av., Long Branch(13)
Ambrose, Anthony, 71 Congress st., Newark (7)
Anderson, John E., Neshanic (18)
Anderson, J. F., 195 College av., N. Brunswick(12)
Anderson, R. M., Hackensack (2)
Anderson, Richard D., Burlington (3)
Anderson, Wm., 20 King's Highw'y,W.Hadd'nf'd(4)
Andreae, Paul, 52 Warner av., Jersey City (9)
Andrews, Clarence L., 1616 Pacific av., Atl.City(1)
Andrus. David L., 805 Cooper st., Camden (4)
Angelillis, P., Hackensack (2)
Angelillo, Marc C., 333 Clifton av., Newark (7)
Angelo, Jos. A., 1190 P'ters'n Plank rd., Secausus(9)
Antonius, N. A., 27 W. Market st., Newark (7)
Apgar, Francis A., Oldwick (10)
Applebaum, I. L., 394 Fairmount av., Newark (7)
Applegate, Edw. T. R., 1125 Greenw'd av.,Tr'nt'n(11)
Applegate, Grov. T., 116 Liv'gs'n av., N. B'nsw'k(12)
Applestein, Robert,, 569 E. State st., Trenton (11)
Appleton, Ralph, Farmingdale (13)
Appold, George D., Bergenfield (2)
Areson, Wm. H., 153 B'vue av., U. Montelair (7)
Aria, Michael, 31 Glenwood av., Jersey City (9)
Arlitz, William J., 107 Newark st., Hoboken (9)
Armstrong, L. B., 121 S. Euclid av., Westfield (20)
Armstrong, Robt. R., 114 Pennington av., Pas'c (16)
Aronis, H. R., 239 E. Hanover st., Trenton (11)
Aronowitz, H., 68 Weequahic av., Newark (7)
Arthur, Frances, 138 Westfield av., Elizabeth (20)
Ash, Arthur F., 710 Boulevard East, Weehawken(9)
Ash, Frank W., 108 Carroll st., Paterson (16)
Asheraft, Samuel F., Mulica Hill (8)
Asher, Maurice, 186 Clinton av., Newark (7)
Ashley, H. H., 192 W. State st., Trenton (11)
Aszody, Paul, 340 Waverly av., Newark (7)
Atkinson, Alvan W., 423 E. State st., Trenton (11)
Atkinson, Jas. W., 485 S. Maple av., Glen Rock(16)
Atwell, David R., 920 Hudson st., Hoboken (9)
Auriemma, Michael, 419 Adams st., Hoboken (9)
Austin, T. R., 16 Alden st., Cranford (20)
Avery, Phillip S., Mid'es'x Gen.Hos. N.Br'sw'k (12)
Avidan, Maurice S., 30 Stratford pl., Newark (7)
Axford, W. H., Chester (9)
Axilrod, Maurice, 2620 Pacific av., Alt. City (1)

ASSOCIATE MEMBERS

Aikman, E. M., 30 Oak Lane, Essex Fells (7)
Albano, Enrico H., 242 Clifton av., Newark (7)
Allen, Raymond N., 144 Harrison st., E. Orange(7)
Amdur, Louis A., 834 Westside av., Jersey City (9)
Aronowitz, Harry, 11 E. 42nd st., Bayonne (9)

HONORARY MEMBER

Ard, Frank C., Plainfield (20)

ACTIVE MEMBERS

Babbitt, Hugh M., Jr., 113 W. 7th st., P'nfld (20)
Bacon, Mary, Bridgeton (6)
Bachmann, Wm,. 87 Hilcrest ter., East Orange (7)
Baechler, Jules, 439 16th st., West New York (9)
Baeseman, R. W., 501 Grand av., Asbury Park (13)
Bagg, Linus W., 31 Lincoln Park, Newark (7)
Bahnson, Conrad M., 170 Bowers st., Jersey City(9)
Bailey, Chas. P., 422 Fifth av., Lakewood (13)
Bailey, Wilson G., 512 Broadway, Camden (4)
Bailyn, Emanuel, 331 16th st., West New York (9)
Baird, T. M., 124 Grand pl., Arlington (7)
Baker, Augustus L., 389 W.Bl'kwell av., Dover(14)
Baker, B. S., Skillman (18)
Baker, Charles F., 198 Clinton av., Newark (7)
Baker, Elsworth F., State Hospital, Marlboro (13)
Baker, Hugh W., Vineland (6)
Baker, Maclyn, 638 Stuyvesant av., Irvington (7)
Baker, Maurice E., 1149 Kaighn av., Camden (4)
Baker, Philip W., High Bridge (10)

Baker, Raymond Dewitt, 52 DeFor av., Sum'it (20)
Baketel, S. H., Jersey City (2)
Baldauf, Herman, Belvidere (21)
Baldwin, Samuel H., 626 Clinton av., Newark (7)
Baldwin, J. F., Bergenfield (2)
Ballinger, Reeve L., 659 Kearney av., Arlington(9)
Balson, Z. D. B., 884 S. 14th st., Newark (7)
Balze, H. R., Leonia (2)
Banach, Leon, 2747 Boulevard, Jersey City (9)
Banks, Winifred D., 6 N. Munn av., East Orange(7)
Barb, K. B., Baighn & Princess avs., Camden (4)
Barbarito, Wm. N., 135 Bentley av., Jersey City(9)
Barbash, Samuel, 1902 Pacific av., Atl. City (1)
Barbour, Geo. E., Somerville (18)
Barishaw, S. B., 5 Bentley av., Jersey City (9)
Barkhorn, Chas. W., 223 Roseville av., Newark (7)
Barkhorn, Henry C., 45 Johnson av., Newark (7)
Barlow, Frank A., 91 Lafayette av., Passaic (16)
Barnes, J. Wm., Englewood (2)
Barnshaw, Harold M., 2626 Federal st., Camden (4)
Barr, A. H., 830 Wood av., North, Linden (20)
Barr, Joseph, 975 Madison av., Paterson (16)
Barrett, A. F., 835 Montgomery st., Jersey City (9)
Barrett, Joseph F., 230 Parker av., Maplewood (7)
*Barrett, Wesley J., 517 Cooper st., Camden (4)
Barroso-Berner, A., Englewood (2)
Barrows, Arthur M., 440 Hamilton av., Trenton(11)
Barrows, Victor I., Pitman (8)
Barry, R. G., 908 W. State st., Trenton (11)
Bartlett, Clara K., 4301 Atlantic av., Atl. City (1)
Baruch, Rudolph J., 414 Elizabeth av., Eliz. (20)
Basset, Lavern C., 320 New Market rd., Dun'len(12)
Bassett, Norman H., 109 States av., Atl. City (1)
Bauer, Harry W., Palmyra (3)
Baum, Felix, 765 S. 10th st., Newark (7)
Baum, Samuel, 10 Osborne ter., Newark (7)
*Bauman, John J., 2672 Boulevard, Jersey City (9)
*Beach, E. M., Long Branch (13)
Beairsto, E. B., 178 W. State st., Trenton (11)
Beaver, Jennie Dean, 8 Oliphant Park, Mor'st'n(14)
Becker, C. Fred, 620 Benson st., Camden (4)
Becker, Fred W., 14 Clinton pl., Newark (7)
Becker, Leo V., 69 Ward st., Paterson (16)
Becker, Sidney, Keyport (13)
Becket, Geo. C., 350 Springdale av., E. Orange (7)
Beekman, Jesse H., Sayreville (12)
Beekman, John B., Bedminster (18)
Behrens, Herman, 312 Webster av., Jersey City(9)
Beideman, Caspar M., 5 W. Maple av.,M'tville (4)
Beir, I. R., Harvorford Apts., Atlantic City (1)
Beisler, Lawrence G., 1528 N.Broad st., Hillside(20)
Belfer, J. J., 1235 Chamber st., Trenton (11)
Belford, R. J., 90 Nassau st., Princeton (11)
Beling, Chris. C., 109 Clinton av., Newark (7)
Bell, J. Finley, Englewood (2)
Bell, Thomas, 340 Belmont av., Newark (7)
Bellak, Ellis R., Leesburg (6)
Bellis, Horace D., 437 E. State st., Trenton (11)
Belting, Arthur W., 202 E. Hanover st., T'nton (11)
Ben-Asher, Solomon, 260 Bergen av., J'rs'y Cy (9)
Bender, Theo. T., 666 Broadway, Paterson (16)
Benedict, A. C., 121 Irvington av., South Orange(7)
Bengeisdorf, A., 29 Clinton pl., Newark (7)
Benjamin, Harold C., 59 Crescent av. J'rs'y City(9)
Bennett, Samuel D., Millville (6)
Bennett, W. F., Essex Co. Sanatorium, Verona (7)
Bensley, Maynard G., 129 Summit av., Summit (20)
Bentley, David F., Jr., 406 Cooper st., Camden (4)
Beradinelli, C. G., 92 Eighth av., Newark (7)
Berenson, Samuel J., 414 Elizabeth av., Eliz. (20)
Berg, S., 156 Roseville ave., Newark (7)
Berger, Harry, 921 S. Clinton av., Trenton (11)
Berger, W. A., 346 Roseville av., Newark (7)
Bergin, J. V., 315 Broadway, Paterson (16)
Bergman, M. W. 825 S. 10th st., Newark (7)
Berke, R. N., Hackensack (2)
Berkow, Samuel G., 138 Market st., PerthA'boy(12)
Berlin, J. I., 9 Gifford av., Jersey City (9)
Berman, H. Robert, 286 Roseville av., Newark (7)
Berman, Jacob J., 409 Market st., Trenton (11)
Beshlian, Hagop K., 7 Lee pl., Paterson (16)
Betancourt, R. R., 406 Cooper st., Camden (4)
Beveridge, W. W., 100 Grand av., Asbury Park (13)
Beyer, O. J., 42 Laurel av., Irvington (7)
Bianchi, Angelo R., 520 Sanford av., Newark (7)
Bien, Frank A., 999 Clinton av., Irvington (7)
Bigelow, N. S., 117 Irvington av., South Orange (7)
*Binder, Joseph, 422 Bergen av., Jersey City (9)
Binder, Joseph, 149 Garfield av., Long Branch (13)
Binder, Wm. A., 975 Broadway, Woodcliff (9)
Bingham, Arthur W., 144 Harrison st., E.Orange(7)
Bird, Frank L., Netcong (14)
Birdsall, Clarence, 3 Small av., Caldwell (7)
Birrell, R. G., 554 Westminster av., Elizabeth (20)
Bishop, Carl, 928 W. 8th st., Plainfield (20)
Bissett, John V., 29 Hawthorne av., E. Orange (7)
Bitten, Robert M., 33 Romaine av., Jersey City (9)
Black, Alan B., Clarksboro (8)
Black, L. W., Rutherford (2)
Blackburne, George, 490 Central av., Newark (7)
Blackwell, Enoch, 28 W. State st., Trenton (11)
Blair, T. D., 414 Park av., Plainfield (20)
Blaisdel, C. Byron, 489 Broadway, Long Branch(13)
Blakey, A. P., 155 Wegman pkwy, Jersey City (9)
Blampin, Winifred A., Galen Hill, Atl. City (1)
Blanchard, Kenneth, 25 S. Munn av. E. Orange(7)
*Blanchard, O. R., 37 Clinton av., Jersey City (9)
Blaugrund, Samuel, 190 W. State st., Trenton (11)
Bleasby, C., Garfield (2)
Bleick, Theo., E., 61 Van Ness pl., Newark (7)
Bleick, Wm. D., 583 Prospect av., Maplewood (7)
Bleier, Louis, 88 Clinton av., Newark (7)
Blenkle, V. A., Teaneck (2)
Bloch, Harry, 200 E. Jersey st., Elizabeth (20)
Block, Marcus T., 177 Bloomfield av., Newark (7)
Block, Max, 48 N. Fullerton av., Montclair (7)
Bloom, Lawrence H., 8 Market st., Phillipsburg(21)
Blum, Joseph M., 128 Mill st., Trenton (11)
Blumberg, Jack, 504 Westminster av., Elizab'th(20)
Blythe, Roland P., 30 Springfld av., Cranford (20)
Bohi, Louis J., 320 Broadway, Paterson (16)
Bongiorno, Henry D., 516 River st., Paterson (16)
Bono, J., Northvale (2)
Bonomo, Michael J., 477 Springfld av., Newark(7)
Bonynge, Henry A., 123 Prospect st., Ridgewood(16)
Bookrajian, Edw. N., 5459 Boulevard, N. Bergen(9)
Bookstaver, B. S., Teaneck (2)
Booth, Wm. K., Boonton (14)
Boothby, I. R., Clinton (10)
Boozan, Wm. E., 1139 E. Jersey st., Elizabeth (20)
Borow, Benjamin, Bound Brook (18)
Borow, Henry, Bound Brook (18)
Borow, Lewis, Bound Brook (18)
Borow, Maurice, Bound Brook (18)
Borshaw, Hyman, 108 Bentley av., Jersey City (9)
Bortone, Frank, 2765 Boulevard, Jersey City (9)
Bosch, T., Wycoff Township (2)
Boselli, Emile H., 614 15th st., Union City (9)
Bossard, Henry B., Phillipsburg (21)
Bossert, Chas A., 4021 Atlantic av., Atl. City (1)
Bossone, Joseph E., 172 Garfield av., L. Branch(13)
Bostwick, Delazon S., Bridgeton (6)
Bostwick, Wallace R., 56 Church st., M'tclair (7)
Botbyl, B. W., 927 Madison av., Paterson (16)
Botti, John A., 236 Summit av., Jersey City (9)
Boulden, Geo. P., P.O.Box 422. N. Brunswick (12)
Bourns, Edw. G., 126 Harrison av., Westfield (20)
Bove, Joseph, 306 Lincoln av., Orange (7)
Bowersox, C. A., Woodbury (8)
Bowles, Harry H., 36 Woodland av., Summit (20)
Bowman, A. K., 272 Nassau st., Princeton (11)
Bowyer, Frank F., 50 Gifford av., Jersey City (9)

Boyd, John, East Front st., Red Bank (13)
Boyes, J. G., 1326 Chetwynd av., Plainfield (20)
Boylan, Lawrence B., 630 Main st., Paterson (16)
Boysen, Theo. H., 100 Phila. st., Egg Harbor (1)
Brackett, Elizabeth R., 349 Franklin av., Nutley(7)
Bradford, Stella S., 16 Seymour av., Montclair (7)
Bradley, Robert A., 1616 Pacific av., Atl. City (1)
Bradshaw, John H., 27 High st., Orange (7)
Brady, Thos. S., 678 Avenue C., Bayonne (9)
Brady, William, 403 46th st., Union City (9)
Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
Bramble, Halsey S., Elmer (17)
Brancato, Peter, 17 Church st., Paterson (16)
Brandenberg, Leo W., 4260 Boulevard, Un. City(9)
Branin, Howard S., Millville (6)
Brasefield, Edgar N., Phillipsburg (21)
Brauer, Selig, 234 Bergen av., Jersey City (9)
Braun, D. C., Newton (19)
Braun, Gus A., 391 Bergen st., Newark (7)
Braunstein, S. C., 424 13th st., West New York (9)
Braunstein, Wm. P., 831 Boulevard E., W'h'wk'n(9)
Bregman, Alexander, Edgewater (2)
Breitstadt, Charles A., 168 Delavan av., Newark (7)
Brennan, A. T. V., Tenafly (2)
Brennan, Chas. L. S., 14 S. Broadway, Glouc'er (4)
Brennan, John P., 429 Cooper st., Camden (4)
Brennock, Thos. McG., 3 Webster av. J'rs'y City(9)
Breslow, S., 111 Market st., Perth Amboy (12)
Brewer, David R., 536 Market st., Gloucester (4)
Brewer, William, Woodbury (8)
Brick, G. J. 43 Cottage st., Jersey City (9)
Brien, Wm. M., 449 Main st., Orange (7)
Briggs, H., 16 Undercliff ter., West Orange (7)
Brin, Anne J. S., 83 Lincoln Park, Newark (7)
Brittain, Elmer G., Bound Brook (18)
Broadnax, Mary E., 83 Lincoln Park, Newark (7)
Brodkin, Eva T., 365 Osborne ter., Newark (7)
Brodkin, H. A., 365 Osborne ter., Newark (7)
Brody, Morton S., 84 Bayard st., N. Brunsw'k (12)
Broesser, H. V., 105 Newark av., Hoboken (9)
Brokaw, Chris. A., 1405 North av., Elizabeth (20)
Bromberg, Chas. B., 107 Lexington av., Passaic(16)
Brooke, Chas. R., 13 Pennington st., Newark (7)
Brooke, W. W., 915 Ave. C., Bayonne (9)
Brooks, S. S., 62 12th ave., Paterson (16)
Brophy, Francis X., 2511 Boulevard, Jersey City(9)
Brotman, Morton M., 90 Avon av., Newark (7)
Brouwer, Frank, Toms River (15)
Brown, Carlisle J., 101 S. Indiana av., Atl. City (1)
Brown, Chester R., 22 Midland av., Arlington (7)
Brown, Chester T., Prudential Ins. Co., New'k (7)
Brown, E. V., 585 Kearny av., Arlington (7)
Brown, Fred L., 67 Livingston av., N. Brunsw'k(12)
Brown, Harvey S., 5 Club pl., Freehold (13)
Brown, J. L., Grantwood (2)
*Brown, J. Spencer, Montclair (7)
Brown, Kenneth, 603 Asbury av., Asbury Park (13)
Brown, L. Greeley, 173 Madison av., Elizabeth (20)
Brown, Lewis W., 15 Fulton st., Newark (7)
Brown, Richard J., 105 Ridgewood rd., S. Orange(7)
Brown, Stanley, Glen av., Laurel Springs (4)
Brown, William H., 29 3rd st., Elizabeth (20)
Browning, W. K., 120 N. Centre st., Merc'tville (4)
Browning, William J., 134 N. Centre st.,M'rc'tv'le(4)
Brozdowski, John J., 554½ Jersey av., Jer. C'y (9)
Bruder, A. J., 344 Fairmount av., Jersey City (9)
Byrne, James A., Morristown (14)
Buckley, J. L., 666 Franklin av., Nutley (7)
Buckley, P. J., Bogota (2)
Buckley, R. T., Peddie School, Hightstown (11)
Buermann, Robert, Lakewood (15)
Bull, Louis M., 92 Heller Parkway, Newark (7)
Bull, Robert I., 531 W. Market st., Newark (7)
Bull, W. J., 98 Park st., Montclair (7)
Bulwinkle, Fred., Ocean Blvd., Atl. Highlands (13)
Bunn, Frank C., 30 Hillyer st., Orange (7)
Bunnell, Frederick N., Barnegat (15)
Bunting, P. DuBois, 712 N. Broad st., Elizabeth(20)
Burbank, H. E., Lyndhurst (2)
Burke, Stephen E., 212 First av., Newark (7)
Burkett, William, Pitman (8)
Burn, Victor E., Newton (19)
Burne, John J., 17 Gould av., Newark (7)
Burnett, Chas. B., Main st., South River (12)
Burnham, L., Englewood (2)
Burns, Edward L., 269 Broad st., Newark (7)
Burns, G. C. H., Tenafly (2)
Burpeau, Wm. P., 144 Harrison st., E. Orange (7)
Burritt, Norman W., 30 Beachwood rd., Summit(20)
Burroughs, Edm. W., 701 W. State st., Tr'nt'n(11)
Busansky, Samuel T., New Lisbon (3)
Busch, Herman, 38 Johnson av., Newark (7)
Bush, Archer C., 40 Union av., Montclair (7)
Bush, Ralph K., 131 E. Park av., Merchantville (4)
Busicco, P. S., Englewood (2)
Butcher, Charles, Heisleville (6)
Butenas, Jos. J., 300 1st av., Elizabeth (20)
Butler, Eustace C., 249 Bloomfld av., Caldwell (7)
Butler, S. S., 1100 Kaighn av., Camden (4)
Butler, Vincent P., 921 Bergen av., Jersey City (9)
Butterfield, Arey A., Pas. Nat. Bk. Bldg. Passaic(16)
Buvinger, Chas. W., 50 Washington st., E. Or'ge(7)
Buzby B. Franklin, 414 Cooper st., Camden (4)
Byers, C. W., Rutherford (2)
Byington, R., 261 Springfield av., Summit (20)

ASSOCIATE MEMBERS

Barone, Francis A., 175 Fulton st., Jersey City (9)
Barton, J. M., 1314 Spruce st., Philadelphia, Pa.(6)
Bauman, Everett O., 30 Wilbur av., Newark (7)
Belafski, Henry A., 472 Rahway av., W'dbridge(12)
Beling, C. Abbott, 111 Clinton av., Newark (7)
Blinn, Arthur R., 100 Chestnut st., E. Orange (7)
Block, Milton, 1472 W. Clinton av., Irvington (7)
Bocchini, Jos., 336 S. 12th st., Newark (7)
Bonanno, Peter J., 518 35th st., N. Bergen (9)
Borrone, Milton, 2695 Boulevard, Jersey City (9)
Borsher, Irving P., 255 Broad st., Bloomfield (7)
Borzell, F. F., Philadelphia, Pa. (3)
Burtin-Opitz, R., Palisade (2)

ACTIVE MEMBERS

Cacciarelli, Robt. A., 517 Roseville av., Newark(7)
Cahill, L. A., 353 Lafayette st., Newark (7)
Caldroney, T. L., Ridgefield Park (2)
Caldwell, J. A., 45 S. Mountain av. Montclair (7)
Callahan, Edw. J., 640 E. Broad st., Westfield (20)
Calvert, Wm. C., 220 Central av., Orange (7)
Calvin, Charles, 80 Commerce st., Perth Amboy(12)
Camche, L. J., 250 Renner av., Newark (7)
Cameron, Edwin A., 186 S. Burnett st., E. Or'nge(7)
Campbell, Duncan, Woodbury (8)
Campbell, H. B., 21 Court st., Newark (7)
Campbell, J. M., Ramsey (2)
Campbell, Wm., 144 Harrison st., East Orange (7)
Campbell, Wm. K., 96 Third av., Long Branch (13)
Cannon, Edw. A., 5360 Hudson Blvd., N. Bergen(9)
Canright, C. M., 2 Berkley pl., Cranford (20)
Cantini, Raphael, 924 Plainfield av., Pl'nfield (20)
Cantrell, W. C., 88 Union st., Clifton (16)
Carberry, Edw. T., Wharton (14)
Carbone, Francis R., 157 Hunterdon st., Newark(7)
Card, Chas. F., 100 W. Milton av., Rahway (20)
Cardwell, E. P., 47 Central av., Newark (7)
Caridi, Salvatore, 465 Bergenline av., W. NewY'k(9)
Carlander, O. R., 1972 Browning rd., Merc'ntville(4)
Carlin, Edward J., 20 Jacques av., Rahway (20)
Carlisle, John H., 129 Prospect st., Passaic (16)
Carlough, D. J., 426 Ellison st., Paterson (16)
Carman, Fletcher F., 31 Lincoln Park, Newark(7)

Carmona, Louis R., Tuckerton (15)
Carpenter, C. C., 129 Summit av., Summit (20)
Carpenter, William H., Woodbury (8)
Carr, Mary B., 1 Astor pl., Jersey City (9)
Carrigan, Francis P., 288 Franklin av., Nutley (7)
Carrington, Wm. J., 905 Pacific av., Atl. City (1)
Carroll, C. Walter, 117 Centre st., Trenton (11)
*Carroll, Edgar, Dayton (12)
Carroll, T. R., Hudson Heights (2)
Carroll, W. V., 211 Academy st., Trenton (11)
Carter, Joseph F. S., 142 Atkins av. Asb'y Pk (13)
Caruso, Rocco J., 222 Mt. Prospect av., Newark (7)
Casale, John B., 496 Highland av., Newark (7)
Casilli, A. R., 618 Newark av., Elizabeth (20)
Casselman, Arthur J., 301 N. 2nd st., Camden (4)
Cassidy, S. H., Osborn st., Keyport (13)
Catanzaro, F., 151 Jefferson st., Passaic (16)
Cater, Douglas A., 55 Harrison st., East Orange (7)
Cerone, Daniel M., 398 N. 11th st., Newark (7)
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth(20)
Chamberlain, Aims R., 30 Lenox pl., Maplewood(7)
Chapman, E. J., 203 Danforth av., Jersey City (9)
Chapman, O. P., 125 Broad st., Elizabeth (20)
Chapman, R. W., 835 Bergen st., Newark (7)
Charlton, C. Coulter, 124 Illinois av. Atlantic C'y(1)
Chase, W. E., 587 Main st., Passaic (16)
Chayes, Sidney, 980 Ave. C., Bayonne (9)
Chenitz, Wm., 530 Orange st., Newark (7)
Chereshore, Henry, 363 Centre st., Nutley (7)
Cheskin, Louis T., 115 Mapes av., Newark (7)
Chester, Saul W., 264 Graham av., Paterson (16)
Chew, Elisha C., 603 Pacific av., Atlantic City (1)
Chianese, C. Chester, 464 Hamilton av., Trenton(11)
Child, Florence C., 317 City Hall, Trenton (11)
Childers, Robert J., 604 Park av., Plainfield (20)
Chilton, F. S., Pompton Plains (14)
Chisholm, Gibbs, 14 Boston st., Newark (7)
Chmelnik, A. G., 299 Clinton av., Newark (7)
Chrisman, Irving, 408 Ellison st., Paterson (16)
Christensen, A. H., Lebanon (10)
Christian, Henry A., 111 Fairview av., J'rs'y City(9)
Ciliberti, Frank J., 5th & Pine sts., Camden (4)
Clark, Chas. C., 461 New York av., Union City (9)
Clark, Ernest W., 209 Haddon av., Westmont (4)
Clark, Frank G., White House Station (10)
Clark, J. Henry, 108 Orange rd., Montclair (7)
Clark, S. Worth, 152 S. North Carolina av. At Cy(1)
*Clark, William A., Trenton (11)
Clarke, Edward W., West Englewood (2)
Clarke, F. W., 47 Bayard st., New Brunswick (12)
Clarken, Jos. A., 43 Lincoln Park, Newark (7)
Clay, Thomas A., 351 Totowa av., Paterson (16)
Clayton, John C., 73 W. Main st., Freehold (13)
Cleary, Joseph P., Minotola (1)
Clement, L. B., 124 Kings Hgwy, W. Haddonfld(4)
Clippinger, R. D., Vineland (6)
Closson, Edward W., Lambertville (10)
Cloud, A. W., Englewood (2)
Cobham, James L., 78 Brinkerhoff st., J'rs'y City(9)
Coburn, John W., 111 N. Parkway, E. Orange (7)
Cochrane, Cleland C., Closter (2)
Coe, Richard, 156 Clinton av., Newark (7)
Coffin, Henry, 433 Mt. Prospect av., Newark (7)
Cogan, Henry, 128 Carroll st., Paterson (16)
Coghlan, Jasper, 17 Academy st., Newark (7)
Cohen, C. C., 217 W. Hanover st., Trenton (11)
Cohen, Harry F., 660 Jersey av., Jersey City (9)
Cohen, Herman, 489 Jersey av., Jersey City (9)
Cohen, Herman, 1419 Hamilton av., Trenton (11)
Cohen, Herman N., 714 Park av., Hoboken (9)
Cohen, I. E., 561 Elizabeth av., Newark (7)
Cohen, Maurice, 106 Valley rd., Montclair (7)
Cohen, Meyer J., 32 Runyon st., Newark (7)
Cohen, N. B., 232 State st., Perth Amboy (12)
Cohen, Samuel A., 112 Mercer st., Jersey City (9)
Cohen, Sidney L., 20 Avon av., Newark (7)
Cohen, Wm., 1007 Greenwood av., Trenton (11)
Cohn, G. M., 748 S. 10th st., Newark (7)
Cohn, Herman, 393 Clinton av., Newark (7)
Cohn, Royal M., 740 Clinton av., Newark (7)
Cole, Blase, Newton (19)
Cole, L. Frank, 242 Broadway, Paterson (16)
Cole, Walter H., Jr., 116 Chilton st., Elizabeth (20)
Coleman, A. H., Clinton (10)
Coleman, Joseph G., Hamburg (19)
Colfax, Wm. S., 33 Bartholf av., P'pton Lakes (16)
Collier, Martin H., Camden Co. Hosp. Lakeland (4)
Collier, Wm. S., 1000 S. Broad st., Trenton (11)
Collins, Henry J., 1160 Hamilton av., Trenton (11)
Collins, James J., Main st., Woodbridge (12)
Collins, Lawrence M., Greystone Park (14)
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood(7)
Comando, Harry N., 690 Clinton av., Newark (7)
Comeau, G., Morris Plains (14)
Comfort, John B., 50 S. Clinton av., Trenton (11)
Communale, A. R., 63 Irving st., Rahway (20)
Comora, Herman C., 317 16th st., W. New York (9)
Conaway, Walt. P., 1723 Pacific av., Atlantic Cy(1)
Condon, John F., 686 Mt. Prospect av., Newark (7)
Condon, W. J., 50 Livingston av., N. Br'swick(12)
Conlon, Philip, 25 James st., Newark (7)
Connomacher, H. S., 27 Woodland rd., Maplew'd (7)
Connell, Emmet J., 2227 Blvd., Jersey City (9)
Connell, John, 977 Summit av., Jersey City (9)
Connell, John N., 26 Carlton av., Jersey City (9)
Connelly, John A., 212 W State st., Trenton (11)
Connolly, John J., 212 Market st., Newark (7)
Connolly, Richard N., City Hospital, Newark (7)
Connolly, T. Vincent, 54 Hamilton st., Paterson(16)
Connolly, Thos. W., 921 Bergen av., Jersey City (9)
Connor, Clarence A., Fort Lee (2)
*Conoly, J. Holbert, 300 Monmouth st., Glouc'ter(4)
Conoly, Lacy N., 601 Walnut st., Camden (4)
Conover, E. E., Hasbrouck Heights (2)
Conrad, E. K., Hackensack (2)
Conroy, John S., Burlington (3)
Conty, Anthony J., 318 48th st., Union City (9)
Cook, H. F., 21 Roseville av., Newark (7)
Cock, J., Bound Brook (18)
Cooke, Wm. H., 303 Main st., East Orange (7)
Cooley, R. L. Dunellen (18)
Cooper, H. M., Rutherford (2)
Cooper, I. J., 71 Livingston av., N. Brunsw'k (12)
Cooper, J. Howard, East Millstone (18)
Cooperman, Wm., 647 Market st., Newark (7)
Coppela, Edward A., 447 Lexington av., Clifton(16)
Corbusier, H. D., 612 Park av., Plainfield (20)
Corio, Geo. A., 309 S. Clinton av., Trenton (11)
Corn, David, Ridgefield Park (2)
Cornwell, Alfred W., Bridgeton (6)
Corrigan, Patrick H., 1720 S. Broad st., Trenton(11)
Corson, Allen, Ocean City (5)
Corson, Elton S., Bridgeton (6)
Corson, Filbert R., 101 S. Indiana av., Atl. City (1)
Corwin, Theo. W., 671 Broad st., Newark (7)
Cosgrove, Samuel A., 254 Union st., Jersey City (9)
Costello, William Francis, Dover (14)
Costill, Henry B., 371 Hamilton av., Trenton (11)
Cottone, R. J., 683 Princeton av., Trenton (11)
Cottrell, Judson G., 159 Market st., Perth Am'y(12)
Coughlan, Ella A., 10 Oakwood av., Orange (7)
Coughlan, Frank J., 24 Beech st., Arlington (7)
Coultas, A. B., Madison (14)
Coward, Edwin H., 1423 Pacific av., Atl. City (1)
Cowlbeck, H. D., 224 W. State st., Trenton (11)
Cox, Harold G., 208 Stockton st., Hightstown (11)
Cox, John Calvin, 55 Woodland rd., Maplewood (7)
Cox, William W., 27 S. Fullerton av., Montclair (7)
Coxson, H. P., Laurel rd., Stratford (4)
Crabtree, Loren H., 142 Bellevue st., Elizabeth (20)
Craeco, Fred'k A., 51 Palisade av., Union City (9)
Craig, Henry August, Somerville (18)

Crain, W. E., Mount Ephraim (8)
Crandall, John K., Fort Lee (2)
Crane, Bernard, 306 Pacific av., Atlantic City (1)
Crane, Chas. G., 78 Farley av., Newark (7)
*Crane, J. W., State Prison, Trenton (11)
Crankshaw, Chas. W., Prudential Bldg., Newark(7)
Craster, Chas. V., 381 Parker st., Newark (7)
Crawford, Georgiana U., 28 Carnegie av., E. Or. (7)
Crawford, John W., Bedminster (18)
Crecca, Wm. D., 111 Park av., Newark (7)
Cregar, Peter B., 420 Grant av., Plainfield (20)
Cremens, John F., 144 Carroll st., Paterson (16)
Crist, Walter A., 725 Collings av., W. Collo'sw'd (4)
Cronin, Francis J., 730 South st., Elizabeth (20)
Cronk, E. Irving, 57 Livingston av., N.Br'sw'k (12)
Cropper, Chas W., 2540 Hudson Blvd., J'rs'y C'y(9)
Cropsey, Charles D., Rutherford (2)
Crossfield, H. C., 491 So. Orange av., So. Orange(7)
Crounse, D., 84 Broadway, Passaic (16)
Crowe, Aldrich C., Ocean City (5)
Crowley, Joseph W., 4005 Westfield av., Camden(4)
Crowley, Leo F., 148 Belmont av., Jersey City (9)
Cryder, Millard, Cape May Court House (5)
Crystell, E. H., Hillside av., Nutley (7)
Csema, E. J., 151 Somerset st., N. Brunswick (12)
Culver, Geo. M., 25 Glenwood av., Jersey City (9)
Culver, S. Herbert, 75 Magnolia av., Jersey City (9)
Cummins, G. Wyckoff, Belvidere (21)
Cunningham, Charles, Jr., Vineland (6)
Currie, Norman W., 508 Central av., Plainfield (20)
Curry, Marcus A., Greystone Park (14)
Curtis, Donald, Hackensack (2)
Curtis, Elbert A., 65 Central av., Newark (7)
Curtis, Frank W., Stewartsville (21)
Curtis, Grant P., 312 36th st., Union City (9)
Curtis, Howard C., Moorestown (3)

ASSOCIATE MEMBERS

Caggiano, A. P., 136 Grove st., Montclair (7)
Camper, T. T., Camden, Delaware (11)
Caputo, Anthony R., 16 Hewitt av., Belleville (7)
Carabelli, A. A., 1024 Chamber st., Trenton (11)
Carpenter, Marcus E., 114 Storms av., Jers'y C'y(9)
Carroll, Wilfred, 56 Goodwin av., Newark (7)
Cella, Chas. F., 335 Hamilton av., Trenton (11)
Cetrulo, G. I., 218 Mt. Prospect av., Newark (7)
Chesner, Wm. A., 1111 Hamilton av., Trenton (11)
Chimacoff, H., 171 Elizabeth av., Newark (7)
Cieri, Daniel S., 315 Central av., Union City (9)
Claus, C. H., 239 21st st., Irvington (7)
Clayton, James O., 516 Broad st., Newark (7)
Clement, B. L., 31 Lincoln Park, Newark (7)
Cohen, Max, 732 Lyons av., Newark (7)
Cohen, Sidney Peck, 188 High st., Nutley (7)
Cohn, Adele B., 89 Farley av., Newark (7)
Colonna, P. C., Englewood (2)
Colton, Ethan T., Jr., 220 Park st., Montclair (7)
Copleman, H. B., Middlesex Hosp. N. Brunsw'k (12)
Coughlin, John, 43 Arlington av., Jersey City (9)
Cowan, Joseph H., 85 Van Reypen st., Jers'y C'y(9)

ACTIVE MEMBERS

D'Acierno, P., 346 Palisade av., Union Ctiy (9)
D'Acunto, P., 141 Mt. Prospect av., Newark (7).
D'Agostin, Henry, Cliffside (2)
Dalton, S. Eugene, 1616 Pacific av., Atlantic C'y (1)
Daly, E. J., 921 Bergen av., Jersey City (9)
Dandois, George F., Wildwood (5)
Dane, Chas., 61 Scotland rd., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
Danzis, Max, 31 Lincoln Park, Newark (7)
Darby, A. Eugene, Ocean City (5)
D'Arcy, Walter E., 545 E. State st., Trenton (11)
Darden, Walter T., 149 W. Kinney st., Newark (7)
Darlington, Emlen P., New Lisbon (3)
Darnall, Wm. Edgar, 5 S. Morris av., Atl. City (1)
Davenport, Irwin P., 194 W. State st., Trenton (11)
Davenport, Peter B., 764 S. Orange av., Newark (7)
Davey, Thos. N., 41 W. 33rd st., Bayonne (9)
Davidson, C. Spencer, Pennsgrove (17)
Davidson, E. Norwell, 102 Elm st., Linden (20)
Davidson, Harold S., 1616 Pacific av., Atl. City (1)
Davidson, Henry A., 31 Lincoln Park, Newark (7)
Davidson, Louis L., 31 Lincoln Park, Newark (7)
Davidson, M. M., 128 Grand av., Roselle Park (20)
Davies, George A., Elmer (6)
Davies, Geo. W., 15 Fairview av., Verona (7)
Davis, Albert B. 511 Cooper st., Camden (4)
Davis, E. Vernon, Vincentown (3)
Davis, F. C., 129 Summit av., Summit (20)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, Jacob M., Burlington (3)
Davis, Louis, 825 S. 10th st., Newark (7)
Davis, Richard M. A., Salem (17)
Davis, Stanton H., 212 E. 7th st., Plainfield (20)
Davis, W. Cole, 124 S. Illinois av., Atlantic City (1)
Davison, Royden W., 205 W. State st., Trenton (11)
Dawson, Harry E., 618 24th st., Paterson (16)
Day, Grafton E., Frazier & N. J. avs.,Collingsw'd(4)
Day, Samuel Thomas, Port Norris (6)
Day, Willis B., 154 E. 7th st., Plainfield (20)
Dayton, S. T., Englewood (2)
DeCesare, F. D., 500 Walnut st., Roselle Park (20)
Decker, Charles T., 178 Elm st., Westfield (20)
Decker, Clinton L., 40 S. Kingman rd., S. Orange(7)
Decker, J. G., Hasbrouck Heights (2)
DeFreitas, Clement, 423 W. 4th st., Plainfield (20)
DeFronzo, Morando, 180 Fairmount av., Newark (7)
DeFuccio, C. P., 47 Glenwood av., Jersey City (9)
deHellebranth, R. T., 104 S. Frankf't av., Ventnor(1)
Deibert, Irvin E., 618 Benson st., Camden (4)
Deignan, Wm. L., 257 Dodd st., East Orange (7)
Delario, A. J., 56 Cross st., Paterson (16)
DelDeo, Nicholas V., 47½ State st., Newark (7)
Del Duca, Vincent 406 Cooper st., Camden (4)
Del Guercio, O., 342 Clifton av., Newark (7)
Demarest, J. W., Hackensack (2)
Demarest, L. M., 228 S. Orange av., S. Orange (7)
DeMattia, Michael, 71 Cedar st., Paterson (16)
DeMeritt, C. L., 1225 Bloomfield st., Hoboken (9)
Denbo, Elic, 8154 Haddon av., Camden (4)
Denelsbeck, J. Otis, 878 E. State st., Trenton (11)
Denes, O. J., 402 Centre av., Nutley (7)
Dengler, H. P., Morris av., Springfield (20)
Denig, R. D., Hackensack (2)
Dennin, Jos. W., 308 Chestnut st., Roselle (20)
Denton, Peter P., 951 Madison av., Paterson (16)
DePons, S. R., 501 Grand av., Red Bank (13)
Deriveaux, John A., 103 Clniton av., Newark (7)
DeRosa, Armond, 290 Union Blvd., Paterson (16)
DeRosa, John, 150 Fair st., Paterson (16)
DeSanto, A. M., Hackensack (2)
Deutel, Oscar R., 283 Franklin st., Bloomfield (7)
DeVausney, Winfield S., 50 James st., Newark (7)
DeVincentis, Henry, 285 Henry st., Orange (7)
Devlin, Frank, 617 Broadway, Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
Dewis, Edwin G., 1018 Fourth av., Asbury Park (13)
Dexter, Harriet E. T., 903 Ave. C, Bayonne (9)
De Yoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Charles N., Hackensack (2)
D'Gianni, N. H., 911 Hamilton av., Trenton (11)
Dias, Joseph L., 17 Lombardy st., Newark (7)
Dickson, J. D., Bogota (2)
Dieckman, C., Morristown (14)
Dieffenbach, Rich. H., 570 Mt. Pr'sp'ct av., N'w'k(7)
Dieker, Howard, 78 Main st., South River (12)
Dilger, F. G., Hackensack (2)
Dillingham, W. I., 431 15th st., West New York (9)
Dinge, Ferdinand Chas., 67 S. Munn av., E. Or.(7)

Dingman, N. M., 330 Broadway, Paterson (16)
Disbrow, G. Ward, 126 Mountain av., Summit (20)
Disbrow, Harold B., Lakewood (15)
Disbrow, Vanderhoof M., Lakewood (15)
Diverty, Henry B., Woodbury (8)
Dodd, Edward L., 151 Forest st., Belleville (7)
Dodd, Wm. E., Beach Haven (15)
Dodson, Louis, 592 Jersey av., Jersey City (9)
Doggert, E. Hugh, 713 Watchung av., Plainfield (20)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Donahue, Wm. J., 173 Roseville av., Newark (7)
Donohoe, Lucius F., 140 West 8th st., Bayonne (9)
Donnald, E. Cox, 416 West av., N. Linden (20)
Donnelly, Robert J., 208 Market st., Newark (7)
Donovan, J., Greystone Park (14)
Donovan, William F., Brielle (13)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 921 Bergen av., Jersey City (9)
Doranz, H. K., 38 S. Hermitage av., Trenton (11)
Doremus, Widmer E., 375 Mt. Pr'sp'ct av.,N'w'k(7)
Dorn, Elliot I., 267 Vassar av., Newark (7)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Douglas, R., Englewood (2)
*Douress, Philip C., 802 E. State st., Trenton (11)
Downs, Elwood E., Woodbury (8)
Downs, L. S., 76 Washington av., Carteret (12)
Downs, Roscius I., Riverside (3)
Dragonetti, E. N., 177 Clifton av., Newark (7)
Drake, Daniel E., Gr'nw'd Lake rd., Newf'ndl'd(16)
Drake, L. B., Ogdensburg (19)
Drake, Paul F., Phillipsburg (21)
Dranow, Paul, 205 Franklin av., Nutley (7)
Dreskin, J. L., 172 Lyons av., Newark (7)
Drezner, H. L., 521 S. Warren st., Trenton (11)
Driscoll, Chas. D., 6 White Horse Pk.,Hadd'nH'ts(4)
Drury, Alfred J., 268 E. 3rd av., Roselle Park (20)
DuBois, M. G., 769 High st., Newark (7)
duBusc, L. C. Vietor, 399 Westfield av., Eliz'b'th(20)
Dukes, H. R., 220 Kearny av., Kearny (9)
Duckett, Warren, 21 Carlton av., Jersey City (9)
Duffy, J. F., Westwood (2)
Dulin, Everett K., 144 Harrison st., East Orange (7)
Dundon, A. H., North Plainfield (18)
Dunn, John S., Salem (17)
Dunn, Theodore B., 194 Broad st., Bloomfield (7)
Dunning, Walter L., 533 River st., Paterson (16)
Durant, H. J., 661 E. 23rd st., Paterson (16)
Durham, Robert B., 114 S. Illinois av., Atl. City (1)
Durham, Royal E., 114 S. Illinois av., Atl. City (1)
Durrah, Fred. F., 310 Plainfield av., Plainfield (20)
Dwoyer, Leon C., 801 Wood av., Linden (20)
Dwyer, Henry E., 261 Madison av., Passaic (16)
Dwyer, Wm. A. 99 Park av., Paterson (16)

ASSOCIATE MEMBERS

Danielson, John H., 65 Fulton st., Weehawken (9)
Davidson, M., Carteret (12)
Davis, Thos. C., 16 Old Short Hills rd., Millburn (7)
*DeCosta, J. C., 2045 Walnut st., Philadelphia,Pa.(6)
DeFino, F. J., 463 N. 7th st., Newark (7)
DeFusco, G. T., 330 Newark av., Jersey City (9)
Degenhardt, Ira H., 51 Liv'gston av.,N.Br'nsw'k(12)
D'Elia, Louis G., Wayne st., Jersey City (9)
Denison, C. W., Ridgewood (2)
Dershimer, Frederick W., 546 Bergen av., Jer.C'y(9)
De Yoanna, Alfred A., 508 4th st., Union City (9)
DiGiacomo, Wm. H., 2 Prospect pl., Newark (7)
Dimun, J. T., 960 S. Broad st., Trenton (11)
Driscoll, Raymond, 919 Boulevard, Bayonne (9)
Downing, P. E., Jamesburg (12)

ACTIVE MEMBERS

Eagleton, Wells P., 15 Lombardy st., Newark (7)
Earp, Ruth, Bernardsville (18)
Eason, S. N., 48 DeForest av., Summit (20)
East, J. Cooper, Skillman (18)
Eaton, Arthur T., 201 4th av., Haddon Heights (4)
Ebenfield, S. W., 344 High st., Newark (7)
Echikson, Joseph I., 845 S. 12th st., Newark (7)
Eckert, William, 672 Palisade av., Union City (9)
Eckhardt, Ralph A., Madison (14)
Edekrant, Walter L., 82 President st., Passaic (16)
Edelen, James J., 280 S. Clinton st., East Orange (7)
Edelson, Samuel, 1141 Corlies av., Neptune (13)
Edgar, Joseph A., 71 Congress st., Jersey City (9)
Edgar, Malcolm S., 129 Summit av., Summit (20)
Edwards, James B., Leonia (2)
Edwards, Lena F., 358 Pacific av., Jersey City (9)
Ehrenfald, Edward, 116 Lexington av., Passaic (16)
Ehrlich, Max, 513 Westfield av., Elizabeth (20)
Eigen, Louis A., 358 Gregory av., West Orange (7)
Ein, Wm. B., 31 Lincoln Park, Newark (7)
Eisenberg, David S., 31 Lincoln Park, Newark (7)
Ekings, Frank P., Paterson (16)
Elias, Elmer J., 827 S. Broad st., Trenton (11)
Ellenson, S. S., 507 4th av., Asbury Park (13)
Ellis, Alexander, 513 Broadway, Camden (4)
Ellis, Moury I., 177 S. Clinton st., East Orange (7)
Ellmers, B. J., Paramus (2)
Elmer, Matthew K., Bridgeton (6)
Ely, Lancelot, Somerville (18)
Emerson, Linn, 310 Main st., Orange (7)
Emmer, S. Wolfe, 234 Clinton av., Newark (7)
Emory, George B., 1 Franklin pl., Morristown (14)
English, James R., 51 Cypress st., Newark (7)
English, John T., 681 Stuyvesant av., Irvgniton (7)
English, Samuel B., Glen Gardner (10)
Enright, J. G., 25 Kensington av., Jersey City (9)
Epler, Don A., 45 Hillside av., Newark (7)
Epstein, Harry H., 225 Perry st., Trenton (11)
Epstein, Henry B., 31 Lincoln Park, Newark (7)
Erickson, G. T., Hackensack (2)
Erler, Eugene W., 119 N. 5th st., Newark (7)
Ernest, Richard B., 240 W. State st., Trenton (11)
Ervin, Millard B., 572 Prospect st., Maplewood (7)
Essertier, Edward P., Hackensack (2)
Etheridge, Charles E., 479 Prospect st., East Or.(7)
Eulner, E. H., 216 Henry st., Perth Amboy (12)
Evans, Charles H., 144 Harrison st., East Orange(7)
Evans, E. E., Pennsgrove (17)
Evans, James L., 893 Park av., North Bergen (9)
Evans, Winborne D., 2704 Westfield av., Camden(4)
Ewens, Arthur E., 3600 Pacific av., Atlantic City (1)
Ewing, Harvey M., 31 Lincoln Park, Newark (7)
Eynon, Harold K., 579 Haddon av., Collingsw'd (4)

ACTIVE MEMBERS

Facciolo, Frank, 562 Boulevard, Bayonne (9)
Fagan, James L., 51 Bayard st., New Brunsw'k (12)
Fager, Rudolph O., 98 Broad st., Bloomfield (7)
Fahrenbruch, F. D., Mt. Holly (3)
Failing, Brayton E., 31 Lincoln Park, Newark (7)
Fairbanks, Warren H., 27 Broadway, Freehold (13)
Faison, John B., 45 Glenwood av., Jersey City (9)
Falcone, C., 197 Sanford st., New Brunswick (12)
Falvello, N. A., Morristown (14)
Fanburg, Sol. J., 31 Lincoln Park, Newark (7)
Fanelli, Antonio, 469 Lowrie st., Perth Amboy (12)
Farden, Jos. L., 342 Roseville av., Newark (7)
Farmer, Vincent, Hackensack (2)
Farmer, W. D., Church st., Allentown (11)
Farr, J. C., 75 10th st., Hoboken (9)
Farr, Irving L., 214 Walnut st., Montclair (7)
Farr, W. T., 288 Griggs av., Teaneck (2)
Farrell, Edgar A., 100 Kings Hwy., W. H'd'nf'ld (4)
Fasano, G., 194 S. 7th st., Newark (7)
Fattel, Henry C., 256 Montgomery st., Jersey C'y (9)
Faughnan, Rose, 97 High st., Passaic (7)

Favorite, Grant O., West Jersey Hosp., Camden (4)
Faulkingham, R. J., 61 Liv'gston av., N. Bruns.(12)
Featherston, Daniel F., 506 4th av., Asury Park (13)
Fechner, Julius, 138 W. Kinney st., Newark (7)
Fee, Elam K., Main st., Lawrenceville (11)
Feher, L. A. M., 177 Somerset st., N. Brunsw'k (12)
Feigenoff, Israel, 420 Broadway, Paterson (16)
Fein, Bernard, 585 Elizabeth av., Newark (7)
Feinberg, Harry D., 384 2nd av., Long Branch (13)
Feinstein, Louis, 401 Pacific av., Atlantic City (1)
Feit, Herman, 921 Bergen av., Jersey City (9)
Fell, Alton S., 529 E. State st., Trenton (11)
Fellman, M., 118 Jewett av., Jersey City (9)
Fendrick, Edward, 91 Watson av., East Orange (7)
Feneck, Chas. C., 510 Roma av., Phoenix, Ariz. (7)
Fenton, Tennent E., 320 Ludlow av., Spring Lk.(13)
Ferenczi, Louis J., 33 Edwards st., Bayonne (9)
Ferguson, Chas., 435 Westminster av., Eliza. (20)
Ferguson, W. E., 1175 Raymond Blvd., Newark (7)
Fern, S. S., 122 Elizabeth av., Newark (7)
Ferriss, Ruth, Morristown (14)
Fessler, A. J., 1544 S. Broad st., Trenton (11)
Fessler, W., Grantwood (2)
Fewsmith, Jos. L., 120 Second av., Newark (7)
Fiedler, M., 1012 E. Jersey st., Elizabeth (20)
Field, Frank L., Far Hills (18)
Fielding, William M., Allendale (2)
Filkins, Cedric E., 418 W. Horse Pike, Audubon (4)
Fine, H. P., 185 Market st., Perth Amboy (12)
Fine, Moses J., 175 Clinton av., Newark (7)
Fineberg, Jacob, 50 Glenwood av., Jersey City (9)
Finegan, P. J., 1012 Hamilton av., Trenton (11)
Finesilver, Edward M., 31 Lincoln Park, Newark (7)
Finke, Chas. H., 317 York st., Jersey City (9)
Finke, George W., Hackensack (2)
Finke, John H. D., Hackensack (2)
Finkel, Joshua, 368 Clinton av., Newark (7)
Finkelstein, A. S., 670 Clinton av., Newark (7)
Finkler, Rita S., 35 Leslie st., Newark (7)
Finn, Frederick A., 921 Bergen av., Jersey City (9)
Fischman, H. H., 34 Sterling st., Newark (7)
Fish, Clyde M., 7 W. Washington av., Pl's'ntv'le(1)
Fisher, James A., 501 Grand av., Asbury Park (13)
Fisher, P. C., Ridgewood (2)
Fisher, Samuel, 808 Madison av., Paterson (16)
Fisher, Stella C., 4401 Westfield av., Camden (4)
Fishkoff, A., 360 State st., Perth Amboy (12)
Fishler, C. F., Clayton (8)
Fitch, Thomas, 744 Watchung av., Plainfield (20)
Fithian, Geo. W., 266 High st., Perth Amboy (12)
Fitzhugh, W. F., Ridgefield Park (2)
Fitzpatrick, Edward F., 574 Warren st., Newark (7)
Fitzpatrick, L., 134 Bergen av., Ridgefield Park (2)
Flaherty, M. E., 36 Glenwood av., Jersey City (9)
Fleming, C. L., Pennsgrove (17)
Flichtenfeld, Morris, 283 4th st., Jersey City (9)
Fliegel, William, Maywood (2)
Flint, Edgar T., Raritan (18)
Flitcroft, William, 510 River st., Paterson (16)
Flower, M. A., 39 Lincoln Park, Newark (7)
Flynn, E. A., 161 Washington av., Belleville (7)
Flynn, Thomas A., Somerville (18)
Fooder, H. M., Williamstown (8)
Ford, Theodore R., 19 Prospect st., Summit (20)
Forer, Robert, 247 Centre st., Trenton (11)
Forman, H. S., 640 Bergen av., Jersey City (9)
Forney, Norman N., Main st., Milltown (12)
Forsythe, Kenneth C., 530 Summer av., Newark (7)
Fort, J. Irving, 306 Roseville av., Newark (7)
Forte Frank S., 456 Roseville av., Newark (7)
Foster, Frank C., 320 Springfield av., Cranford (20)
Foster, Herbert W., 2 Erwin Park, Montclair (7)
Foster, W. S., 233 Mt. Prospect av., Newark (7)
Fowler, Royal H., 744 Broad st., Newark (7)
Fox, J. W., Hillsdale (2)
Fox, S. W., Ford av., Fords (12)
Fox, Wm. W., 101 S. Indiana av., Atlantic City (1)
Francis, Adaline M., Somerville (18)
Frank, Morris, 920 Ave. C, Bayonne (9)
Frank, Myrtile, 227 Philadelphia st., Egg Harbor(1)
*Franklin, C. C., 1012 Hamilton av., Trenton (11)
Franklin, I. Harold, 191 Palisade av., Jersey City(9)
Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
Franklin, Louis, 191 Palisade av., Jersey City (9)
Franklin, S. I., Englewood (2)
Fredericks, Gus H., 349 Camden st., Newark (7)
Freeland, A. J., Woodbine (5)
Freeland, Frank, Hackensack (2)
Freeman, George C., 1 Lenox pl., Maplewood (7)
Freeman, Richard D., 103 Scotland rd., S. Orange(7)
Freile, Wm., 25 Tonnele av., Jersey City (9)
Freinkel, Jacob, 2 Hillside av., Newark (7)
*Frey, Albert E., Newark (7)
Friedburg, Geo. H., 1108 Anna st., Elizabeth (20)
Friedman, H. H., 63 W. Main st., Freehold (13)
Friedman, Harry, 721 S. 16th st., Newark (7)
Friedman, Hyman, 1096 Sanford av., Irvington (7)
Friedman, M. H., 526 N. Clinton av., Trenton (11)
Friedmann, Leonard L., 484 Princeton av., Tr'nt'n
Froelich, J. C., 74 Ingraham Pl., Newark (7)
Frohwein, Ida H., 119 Morristown rd., Elizab'th (20)
Froomess, Leo H., 775 High st., Newark (7)
Frost, I. F., Morristown (14)
Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
Fuerstman, H. L., 570 High st., Newark (7)
Fuhrmann, Barclay Stokes, Flemington (10)
Fulper, Theodore B., Hampton (10)
Funk, Joseph, 615 Elizabeth av., Elizabeth (20)
Funkhouser, Edgar B., State Hospital, Trenton (11)
Furlonge, H. Rowland, 333 Forrest st., Jer. City (9)
Furman, Benj. A., 31 Roseville av., Newark (7)
Furst, Nathan J., 190 Johnson av., Newark (7)

ASSOCIATE MEMBERS

Faber, Edward, 101 Wegman Pkwy., Jersey City (9)
Federer, John J., 821 Blvd. East, Weehawken (9)
Fialk, Harry, 996 Hudson av., Jersey City (9)
Fine, Sidney G., N. J. State Hospital, Trenton (11)
Flanagan, John J., 15 Fulton st., Newark (7)
Fortunato, Jos. F., 224 Van Buren st., Newark (7)
Fost, William H., 107 Franklin st., Belleville (7)
Frank, Nathan, 186 Bowers st., Jersey City (9)
Franzoni, A. E., 938 Brunswick av., Trenton (11)
Friedman, Max, 822 Chambers st., Trenton (11)
Frieman, Hyman, 744 Ave. C, Bayonne (9)

ACTIVE MEMBERS

Gairdner, T. M., Gibbstown (8)
Galasso, Attilio, 1 Cutler st., Morristown (14)
Gallo, James F., Haledon (16)
Gallo, James S., 32 Zabriske st., Haledon (16)
Galloway, George E., 109 Milton av., Rahway (20)
Gamon, Robert S., 558 Newton av., Camden (4)
Gandy, Charles M., Ocean City (5)
Ganley, Arthur J., 390 Park av., East Orange (7)
Ganot, F. I., 639 Ridge st., Newark (7)
Gardam, J. W., 16 Longfellow av., Newark (7)
Garrabrant, Clarence, 19 N. Penn. av., Atl. City (1)
Garrett, Harry S., Park Ridge (2)
Garrison, Walter Sherman, Cedarville (6)
Gauch, Wm., 177 Ellwood av., Newark (7)
Gauzza, Valentine P., Fords (12)
Geary, Daniel J., Morristown (14)
Geary, Paul, 923 Park av., Plainfield (20)
Geary, Russell D., Riverside (3)

Geissler, Elmer E., 327 Monmouth st., Gloucester(4)
Gelber, L. J., 41 Lincoln Park, Newark (7)
Gennell, Ernest, 298 Parker st., Newark (7)
George, M. E. W., 805 Broadway, Newark (7)
Gershman, J. C., 99 Madison av., Dumont (2)
Gerendasy, J., 225 E. Jersey st., Elizabeth (20)
German, Geo. B., 429 Cooper st., Camden (4)
Gershenfeld, David B., 20 Hillside av., Newark (7)
Gesswein, Carl A., Church st., Keyport (13)
Ghee, Euclid P., 115 Clairmont av., Jersey City (9)
Giambra, S. M., 666 Broadway, Paterson (16)
Gibb, W. Blake, Morristown (14)
Gibbs, Alice S., 339 Union av., Elizabeth (20)
Gifford, W. Royal, 247 Park av., East Orange (7)
Giglio, A. S. V., 626 Elizabeth av., Elizabeth (20)
Gilady, Ralph, Hackensack (2)
Gilbertson, R. L., Madison (14)
Gille, Hugo, 149 Congress st., Jersey City (9)
Gillett, H. E., Ramsey (2)
Gillson, Hugh V., 21 Lee pl., Paterson (16)
Gillson, John T., 170 Broadway, Paterson (16)
Gilman, Malcolm B., 59 Seely av., Arlington (7)
*Gilpin, Friend B., 118 North av. W., Cranford (20)
Ginsberg, George, 624 Bloomfield st., Hoboken (9)
Ginsberg, Samuel, 136 Broadway, Passaic (16)
Gittelman, Morton, 1028 E. Jersey st., Elizabeth(20)
Gittlesohn, I., Hackensack (2)
Glasgow, Thomas, 120 Passaic av., Passaic (16)
Glass, Bejamin E., 609 Watchung av., Plainfield (20)
Glass, Oscar, 838 S. 12th st., Newark (7)
Glass, William H., 144 Harrison st., East Orange (7)
Glasston, H. M., 628 N. Wood av., Linden (20)
Glazebrook, F. H., Morristown (14)
Gleeson, Wm. John, 37 Monticello av., Jer. City (9)
Glover, Lawrence L., 53 King's Hwy., H'd'nf'ld (4)
Gnasso, E. R., Fort Lee (2)
Gochman, Henry M., 166 Hamilton av., Paterson(16)
Godfrey, Allan O., 220 Roseville ave., Newark (7)
Godlin, David R., 610 36th st., N. Bergen (9)
Goeller, J. D., 1165 W. Clinton av., Irvnigton (7)
Goff, Frank J,. 64 Maple av., Red Bank (13)
Goffman, Emanuel, 81 Valley rd., Montclair (7)
Goldberg, Benjamin M., 1156 E. State st., Tr'nt'n(11)
Goldberg, David, Westwood (2)
Goldberg, H. H., 814 S. 10th st., Newark (7)
Goldberg, I., 303 N. Washington av., Dunellen (12)
Goldberg, Louis E., 31 Lincoln Park, Newark (7)
Goldberg, Samuel A., 46 Farley av., Newark (7)
Goldberg, Samuel M., 353 Washing'n av., Bell'v'le(7)
Golden, William M., 70 Irving st., Rahway (20)
Goldfarb, A., Rutherford (2)
Goldfield, Harold H., 225 E. Jersey st., Elizabeth(20)
Golding, Harry N., 180 Carroll st., Paterson (16)
Goldstein, A., Lakewood (15)
Goldstein, H. H., 1065 E. Jersey st., Elizabeth (20)
Goldstein, Henry Z., 31 Lincoln Park, Newark (7)
Goldstein, Hyman I., 1425 Broadway, Camden (4)
Goldstein, Samuel, 36 W. Main st., Mays L'nd'g (1)
Goldstein, W. H., 632 Belgrove dr., Arlington (7)
Gonczy, Edward J., 23 Elm st., Elizabeth (20)
Gonzales, W. G., 638 Hudson st., Hoboken (9)
Goodfellow, G. P., 526 Park av., East Orange (7)
Goodrich, S. L., 466 Highland av., Orange (20)
Gorczyca, A. G., 538 S. Broad st., Elizabeth (20)
Gordon, A., 616 Main av., Passaic (16)
Gordon, A. J., 273 Roseville av., Newark (7)
Gordon, Carl, 1414 Pacific av., Atlantic City (1)
Gordon, Charles D., Mt. Arlington (14)
Gordon, Clark H., 808 E. State st., Trenton (11)
Gordon, F. S., Blairstown (21)
Gordon, I. L., 1815 Boulevard, Jersey City (9)
Gordon, J. B., N. J. State Hospital, Marlboro (13)
Gordon, Osher, 119 Lexington av., Passaic (16)
Gorson, Samuel F., 1905 Pacific av., Atlantic City(1)
Gosling, W. W., 23 Monmouth av., Red Bank (13)
Goudy, E. S., 187 Kearny av., Kearny (9)
Gould, J. H., 696 Ave. C, Bayonne (9)
Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
Graham, A. F., 42 Park av., Paterson (16)
Graham, E. E., P. O. Box 195, Yardville (11)
Graham, Richard B., 90 Midland av., Arlington (7)
Graham, Theodore K., 278 Park av., Paterson (16)
Gramsch, A. Louis, Glen Gardner (10)
Grant, William F., 162 Roseville av., Newark (7)
Graves, Charles, State Hospital, Marlboro (13)
Gray, Charles M., Vineland (6)
Gray, John W., 142 Clinton av., Newark (7)
Gray, W. B., North Plainfield (18)
Green, David W., Salem (17)
Green James S., 463 N. Broad st., Elizabeth (20)
Greenberg, George A., Somerville (18)
Greenberg, Philip, 1902 Hudson Blvd., Jer. City (9)
Greenberg, Samuel, 46 Johnson av., Newark (7)
Greene, Albert D., 195 Palisade av., Union City (9)
Greenfield, A. W., Hackensack (2)
Greenfield, B. H., 691 Clinton av., Newark (7)
Greenfield, W. J., Hackensack (2)
Greengrass, Jacob J., 146 Broadway, Paterson (16)
Gregerius, Ralph F., 120 Irvington av., S. Or. (7)
Gregory, Marie F., Green Village rd., Madison (14)
Gregory, Mildred G., 21 Roseville av., Newark (7)
Gregory, R. A., 121 E. 7th st., Plainfield (20)
Greifinger, Marcus H., 22 Vassar av., Newark (7)
Greissinger, Karl, 422 20th st., West New York (9)
Grier, Robt. M., 50 E. Washington av., Pl's'ntv'le(1)
Griesmier, Zadoc L., 1143 E. Jersey st., Elizab'th(20)
Grieve, James, 88 Market st., Perth Amboy (12)
Griffith, Roy, 909 Broad st., Newark (7)
*Griffiths, C. B., Newark (7)
Grimes, Jesse R., Dumont (2)
Groeschel, A. H., Sussex (19)
Groff, P. A., Little Ferry (2)
Grossblatt, Philip, 70 Baldwin av., Newark (7)
Guglielmelli, A. D., 449 Hamilton av., Trenton (11)
Guidi, Guido M., 212 Christine st., Elizabeth (20)
Guillium, W. H., 505 Fourth av., Asbury Park (13)
Guion, Edward, P. O. Box 418, Atlantic City (1)
Guthrie, W. G., 300 Summer av., Newark (7)
*Gutman, Benj., 51 Livingston av., N. Brunsw'k(12)
Gutowski, Jos. M., 433 Brace av., Perth Amboy (12)
Gutowski, W. T., 104 Grove ter., Irvington (7)

ASSOCIATE MEMBERS

Garibaldi, Louis, 1016 Hudson st., Hoboken (9)
Geller, Samuel, 784 High st., Newark (7)
Ghee, Peter F., 734 Ocean av., Jersey City (9)
Gillen, James H., 14 Duncan av., Jersey City (9)
Glasser, Benjamin F., 316 George st., N. Bruns.(12)
Goldberg, H. C., 182 Market st., Perth Amboy (12)
Goldowsky, Ira, 1866 Boulevard, Jersey City (9)
Goldstein, Joseph B., 3263 Boulevard, Jersey City(9)
Greenfield, L. S., 691 Clinton av., Newark (7)
Griffin, Guy B., 197 S. Centre st., Orange (7)
Gutman, Erwin K., 980 Summit av., Jersey City (9)

ACTIVE MEMBERS

Hackett, Leon W., Washington (21)
Hadley, C. F., 201 W. Maple av., Merchantville (4)
Hagen, Orville R., 266 Van Houten st., Paterson(16)
Hagerty, John F., 212 W. Market st., Newark (7)
Haggerty, D. Leo, 227 N. Warren st., Trenton (11)
Hagney, Fred W., 669 Elizabeth av., Newark (7)
Hahn, Katherine B., 272 Thornden st., S. Orange (7)
Hahn, William, 272 Thornden st., South Orange (7)
Haight, Harry W., Raritan av., N. Brunswick (12)
Haines, Edgar J., Medford (3)

Haines, Emerson S., 501 Grand av., Asbury P'k (13)
Haines, Mabel S., 600 White Horse Pk., Audubon(4)
Haines, W. P., Ocean City (5)
Haines, Wm. H., 600 White Horse Pk., Audubon(4)
Halbach, Robert, 513 Main st., Toms River (15)
Haldeman, Robert E., Mt. Holly (3)
Hall, Percy O., 254 Union st., Jersey City (9)
Hall, W. W., 266 Van Houten st., Paterson (16)
Hallet, Frederick S., Hackensack (2)
Halligan, Earl J., 254 Montgomery st., Jer. City (9)
Halligan, Harold J., 254 Montgomery st., Jer.City(9)
Hallock, W. J., Berkeley Height, Summit (20)
Halpern, H., Englewood (2)
Halpern, Samuel, 504 Pacific av., Atlantic City (1)
Halpern, Sophia L., 271 Palisade av., Union City (9)
Halprin, Harry, 8 Washburn pl., Caldwell (7)
Halsey, Levi W., 61 Church st., Montclair (7)
Halstead, Charles F., Somerville (18)
Hamblin, D. O., Bound Brook (18)
Hambright, A. M., Paterson (16)
Hamilton, L. A., Lambertville (10)
Hammell, F. M., 137 S. Main st., Allentown (11)
Hammer, Walter P., 322 15th st., W. New York (9)
Hammett, Lee J., 760 N. 27th st., Camden (4)
Hanan, Jas. T., 11 The Crescent, Montclair (7)
Haney, John J., 167 Cooper st., Trenton (11)
Hanrahan, Jas. N., 114 E. Broad st., Elizabeth (20)
Harden, Albert S., 540 Warren st., Newark (7)
Hardenberg, D. S., 347 Communipaw av., Jer. C'y(9)
Harhen, Geo. E., 22 Brookside av., Caldwell (7)
Harley, Halvor L., 101 S. Indiana av., Atl. City (1)
Harman, J. R., 1819 S. Broad st., Trenton (11)
Harman, Wm. J., 740 W. State st., Trenton (11)
Harmon, B. M., Verona (10)
Harmon, Harry M., Frenchtown (10)
Harner, M. H., High Bridge (10)
Harney, J. N., Teaneck (2)
Harreys, Chas. W., 714 Broadway, Paterson (16)
Harrington, J. Henry, Rockaway (14)
Harris, Allan, Greenwich (6)
Harrison, Joseph B., 320 E. Broad st., Westfield(20)
Harryman, W. K., Hackensack (2)
Harter, Louis F., 174 Bowers st., Jersey City (9)
Hartman, Luther, Maple Shade (3)
Hartwell, H. A., 777 Boulevard East, Weehawken(9)
Harvey, Edwin H., 20 N. Florida av., Atl. City (1)
Harvey, John W., 818 Ave. C, Bayonne (9)
Harvey, Thos. W., 59 Main st., Orange (7)
Harvey, Thos W., Jr., 59 Main st., Orange (7)
Haseltine, S. L., Hersch Bldg., Elizabeth (20)
Haskell, I. D., 387 Fairmount av., Newark (7)
Hasking, Arthur F., 318 Montgomery st., Jer.C'y(9)
Hasney, Frederick A., 292 Main st., West Orange(7)
Hatch, H. S., Morristown (14)
Hauck, Lydia B., 644 Stuyvseant av., Irvington (7)
Hauck, Wm. H., 644 Stuyvesant av., Irvington (7)
Hausman ,Samuel W., 50 W. Front st., R'd B'nk(13)
Haussling, Francis R., 661 High st., Newark (7)
Haven, Samuel C., 14 Elm st., Morristown (14)
Hawes, V. L., Ramsey (2)
Hawkes, E. Zeh, 84 Washington st., Newark (7)
Hawkes, Stuart Zeh, 84 Washington st., Newark(7)
Hayden, W. G., 412 Main st., Toms River (15)
Hays, Roy G., 567 Haddon av., Collingswood (4)
Haywood, Henry, 3 Elm Row, N. Brunswick (12)
Heath, Louanna, 20 Fairmount av., Newark (7)
Heatley, William, 23 Monmouth st., Red Bank (13)
Hegeman, Runkle F., Somerville (18)
Heil, A. Arling, Milford (10)
Heilbrunn, Julius, 135 Belmont av., Jersey City (9)
Heineken, T. S., 17 Park pl., Bloomfield (7)
Heining, Frank G., Boonton (14)
Heintzelman, B. S., 19 W. 33rd st., Bayonne (9)
Hekimian, J. H., 468 Palisade av., Weehawken (9)
Helff, J. R., Teaneck (2)
Heller, G. H., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)
Hemphill, E., 232 King's Hgwy. E., Haddonf'ld (4)
Henderson, K. P., 124 S. Illinois av., Atlantic C'y(1)
Hendrickson, Bruce, Point Pleasant (15)
Henle, C. B., 671 Springfield av., Newark (7)
Henry, Frank C., 254 State st., Perth Amboy (12)
Henry, Frank C., Jr., 214 Smith st., P. Amboy(12)
Henry, George, Flemington (10)
Henry, Jonas A., 1204 Columbia av., Pleasantville(1)
Herbener, E. G., Lakewood (15)
Herman, John H., 197 S. Centre st., Orange (7)
Hernandez, Manuel, 1974 Hudson Blvd., Jer. C'y(9)
Herold, H. C. H., 1115 Broad st., Newark (7)
Herold, Harvey T., 850 S. 13th st., Newark (7)
Herradora, J. R., 921 Bergen av., Jersey City (9)
Herrington, Lee R., 147 Central av., Westfield (20)
Herrman, Wm. G., 501 Grand av., Asbury Park (13)
Hersh, David H., 658 Springfield av., Newark (7)
Hess, L. Elmore, Absecon (1)
Hessert, Edmund C., Haddon & Col.avs.,Col'gsw'd(4)
Hewson, James S., 163 Myrtle av., Millburn (7)
Hexamer, Fred, 50 Lyons av., Newark (7)
Heyman, Arthur, 79 Baldwin av., Newark (7)
Hicks, William H., 46 Milford av., Newark (7)
Hiden, J. C., 199 Nassau st., Princeton (11)
Higgins, G. L., 94 Lembeck av., Jersey City (9)
Higgins, Thos. A., 2616 Hudson Blvd., Jersey City(9)
Hilker, G. F., 258 Maple st., Perth Amboy (12)
Hill, J. A., 511 Cedar av., Allenhurst (13)
Hill, Robert H., 332 Park av., Newark (7)
Hill, William F., 108 Grand st., Jersey City (9)
Hillegas, E. J., Mantua (8)
Hilliard, William T., Salem (17)
Hillsman, R. B., Teaneck (2)
Hilton, C. O., 598 N. 5th st., Newark (7)
Hinton, S. H., Parlin (12)
Hipple, Percy L., Jr., 225 Walnut st., Roselle (20)
Hirschfield, B. A., 1404 Greenwood av., Trenton (11)
Hirst, E. Reed, 634 Federal st., Camden (4)
Hirst, Levi B., 634 Federal st., Camden (4)
Hitzeman, L. A., 30 E. Passaic st., Maywood (2)
Hnat, Frederick, 417 Madison av., Elizabeth (20)
Hoagland, Louis B., Oxford (21)
Hobart, Richard T., 191 Bellev'le av., U. M'ntcl'r (7)
Hofer, Clarence J., Metuchen (12)
Hoffman, C. A., 302 E. 7th st., Plainfield (20)
Hoffman, Florentine M., 91 Bayard st., N. Br'ns.(12)
Hoffman, Harry S., 1912 Pacific av., Atlantic C'y(1)
Hoffman, P., 2672 Boulevard, Jersey City (9)
Hogan, Carlton P., Burlington (3)
Hoheb, A. S., Rutherford (2)
Hoheb, K. R., Rutherford (2)
Holden, Edgar, Jr., 217 Broadway, Newark (7)
Holland, Geo. A., 364 Clinton av., Newark (7)
Holland, John A., 54 Prospect st., Trenton (11)
Holland, Ruben J., Chandler av., Linden (20)
Holler, Henry G., 234 Montclair av., Newark (7)
Hollingshead, Lyman B., Pemberton (3)
Hollinshed, Beulah S., 600 Benson st., Camden (4)
Hollinshed, Ralph K., Westville (8)
Hollywood, Jas. L., 1818 Hudson Blvd., Jer. C'y (9)
Holman, Francis W., 133 Broad st., Keyport (13)
Holmes, F. J. E., 151 Fair st., Paterson (16)
Holmes, Geo. J., 17 Elizabeth av., Newark (7)
Holmes, Grace A., 1077 E. Jersey st., Elizabeth (20)
Holoman, M. Browne, 3 N. Granville av.,Margate(1)
Holt, Edward Z., Child. Seashore Home, Atl. C'y(1)
Holt, Herman Harold, 285 Graham av., Paterson(16)
Holters, Otto R., 513 2nd av., Asbury Park (13)
Holtzman, Michael, 167 2nd st., Elizabeth (20)
Hommell, P. E., 689 Bergen av., Jersey City (9)
Hood, Philip G., 19 Lincoln Park, Newark (7)

Hoops. Harold J., 2203 Blvd., Jersey City (9)
Hoover, A. R., 5 Prince st., Elizabeth (20)
Horn, Max, 94 Lyons av. .Newark (7)
Hornberger, J. Howard, Roebling (3)
Horner-Roger, Clara L., 721 Cooper st., Camden (4)
Hornstine, H. H., Wildwood (5)
Horre, Geo. W. H., 203 W. Jersey st., Elizabeth (20)
Horsford, Fred C., 305 Broadway, Newark (7)
Horowitz, H. J., Morsemere (2)
Hosp, Paul H., 842 S. 12th st., Newark (7)
Houck, W. J., 207 Mt. Prospect av., Newark (7)
Howard, J. Edgar, 67 Kings H'way, W. Hadd'nf'd(4)
Howley, Barth M., 419 George st., N. Brunsw'k(12)
Hubbard, Fayette E., 65 Church st., Montclair (7)
Hubbard, Harry H. V., 121 E. 7th st., Plainfield (20)
Hubbard, Robert Y., 58 Myrtle av., Irvington (7)
Hubbard, S. T., Hackensack (2)
Huber, Wm. H., 15 Salem st., Newark (7)
Huberman, John, 853 S. 12th st., Newark (7)
Hubert, Antonio, 133 Main st., Rockaway (14)
Hudson, W. J., 39 W. Washington av., Pl's'ntv'le(1)
Huff, Edmund N., Englewood (2)
Hughes, Frank R., Cape May (5)
Hughes, Frederick J., 706 Park av., Plainfield (20)
Hughes, Lee W., 965 Broad st.. Newark (7)
Hughes, Thos. E., 223 Cooper st., Camden (4)
Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
Hull, D. B., Ridgewood (2)
Hummel, Ernest G., 414 Cooper st., Camden (4)
Hummel, L. C., Salem (17)
Hummel, Merwin L., 135 N. Centre st.,M'rch'tv'le(4)
Humphries, Robert E., 637 Central av., E. Or. (7)
Hunt, A. C., 625 Middlesex av., Metuchen (12)
Hunt, Geo. Halsey, 129 Broad st., Red Bank (13)
Hunt, Melvin M., 16 Jackson st.. South River (12)
Hunter, Edward R., Delanco (3)
Hunter, F. D., 3620 Nottingham way, Trenton (11)
Hurd, Emerson F., Bound Brook (18)
Hurff, Jos. W., 86 Washington st., Newark (7)
Husserl, Siegfried, 777 Clinton av., Newark (7)
Husted, S. H., Neshanic (18)
Hutcheson, Chas. R., 517 Cooper st., Camden (4)
Hutchinson, A. D., 913 W. State st., Trenton (11)
Hutchinson, G. F., Hamilton Square (11)
Hutton, F. T., 161 Crescent av., Plainfield (20)
Hyer, Oscar H., 210 Main st., Matawan (13)
Hyman, Chas., 1616 Pacific av., Atlantic City (1)

ASSOCIATE MEMBERS

Haley, Paul W., 229 Smith st., Newark (7)
Hantman, Harold, 530 Orange st., Newark (7)
Harreys, C. W., Ridgewood (2)
Hauber, Eugene A., Sayreville (12)
Hawke, Edward K., N. J. Hospital, Trenton (11)
Hayes, Gerald W., 96 N. Walnut st., East Orange(7)
Higgins, John T., 145 Highland av., Jersey City (9)
Hirst, B. C., 1821 Spruce st., Philadelphia, Pa. (6)
Horoschak, Anna, Woodbridge (12)
Howeth, John L., 14 Duncan av., Jersey City (9)
Hubach, M. F., 401 Franklin st., Bloomfield (7)

ACTIVE MEMBERS

Iams, Samuel H., 34 Mercer st., Princeton (11)
*Ignatoff, M. L., Newark (7)
Ill, Carl H., 188 Clinton av., Newark (7)
Ill, Charles L., 188 Clinton av., Newark (7)
Ill, Edgar A., 1002 Broad st., Newark (7)
Ill, Edward J., 1004 Broad st., Newark (7)
Ill, Herbert M., 188 Clinton av., Newark (7)
Imbleau, J. E. L., 2106 Morris av., Unionville (20)
Imhoff. Robert E., Moorestown (3)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Introcaso, D. A., 45 Crescent av., Jersey City (9)
Ireland, A. G., N. J. Dept. Education, Trenton (11)
Irvin, John S., 1910 Pacific av., Atlantic City (1)
Irving, Albert, Albert Court, Radburn (16)
Irwin, J. H., Englewood (2)
Irwin, Jas. R., 330 Washington av., Belleville (7)
Iserman, Michael, 376 Elmora av., Elizabeth (20)
Ishkhanian, N. I., 656 Palisade av., W. New York(9)
Ives, Edward I., 24 Stevens av., Little Falls (16)
Ivins, Wm. C., 214 E. Hanover st., Trenton (11)
Ivory, Harry, Point Pleasant (15)

ASSOCIATE MEMBER

Inge, G. L., Englewood (2)

ACTIVE MEMBERS

Jack, H. Wesley, 920 Haddon av., Collingswood (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Albert F., 225 Hillside av., Nutley (7)
Jackson, Chas. H., 1250 Pk. Boulevard, Camden (4)
Jackson, D. P. D., Belvidere (21)
Jackson, E. C., 98 Washington st., E. Orange (7)
Jacob, Albert N., Sparta (19)
Jacob, William H., 99 N. Main av., Paterson (16)
Jacobson, John J., 1616 Pacific av., Atlantic City (1)
Jacques, J. Eugenia, 74 Waverly st., Jersey City (9)
Jaffe, Herman M., 2600 Blvd., Jersey City (9)
Jaffin, A. E., 41 Emory st., Jersey City (9)
Jahn, Albert, Passaic National Bk., Passaic (16)
James, Bart M., 31 Lincoln Park, Newark (7)
James, Henry C., Mays Landing (1)
James, W. L., Edgewater (2)
James, William H., Pennsville (17)
James, Wm, L., 31 Lincoln Park, Newark (7)
Jamison, W. F., 501 Grand av., Asbury Park (13)
Jani, Frank, 297 Lexington av., Passaic (16)
Janifer, Clarence S., 208 Parker st., Newark (7)
Jarmulowsky, Harry, 237 Broadway, Paterson (16)
Jarrett, Harry, 925 Broadway, Camden (4)
Jaso, James V., 274 Littleton av., Newark (7)
Jaspan, Samuel C., 820 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jentz, John H., 63 Sherman pl., Jersey City (9)
Jessurun, S. H., 613 High st., Newark (7)
Joelson, Morris S., 577 Broadway, Paterson (16)
Johnsen, S. W., 49 Passaic av., Passaic (16)
Johnson, Chas. H., 632 Benson st., Camden (4)
Johnson, G. L., Englewood (2)
Johnson, George, Branchville (19)
Johnson, Harold F., 734 Park av., Plainfield (20)
Johnson, V. Earl, Med. Science Bldg., Atl. City (1)
Johnston, Julian F., Chatham (14)
Johnston, R. O., Harrington Park (2)
Johnston, S. F., Rochelle Park (2)
Jones, Granville L., N. J. State Hosp., Marlboro (13)
Jones, J. Morgan, Valley rd., R.F.D., Oakland (9)
Jones Lewis H., 139 Grant av. E., Roselle Park (20)
Jonitz, Robert, 157 S. Grove st., East Orange (7)
Jordan, J. C., 238 E. Main st., Manasquan (13)
Jordan, W. L., Englewood (2)
Joseph, B. M., 2771 Boulevard, Jersey City (9)
Joseph, Morris, 271 Lexington av., Passaic (16)
Judge, John F., 1009 S. Orange av., Newark (7)
Jukofsky, I. D, Ridgefield Park (2)
Just, Francis, 566 High st., Newark (7)
Justin, Arthur W., 41 Fulton st., Weehawken (9)
Justin, J. Clement, 413 16th st., W. New York (9)

ASSOCIATE MEMBERS

Jablonski, J. J., South River (12)
Jacobson, Murray B., 241 State st., P. Amboy (12)
Jaffe, Benjamin, 568 Bergen av., Jersey City (9)

Jennings, Robt. E., 143 Park st., E. Orange (7)
Johnson, O. W., Rugby, North Dakota (7)
Jost, Franz, 98 Washington st., E. Orange (7)

ACTIVE MEMBERS

Kachdorian, Vartan, 930 Brunswick av., Trent'n(11)
Kahn, Leo, 32 States av., Atlantic City (1)
Kahrs, Grace M., 375 Mt. Prospect av., Newark (7)
Kaighn, Chas. B., 905 Pacific av., Atlantic City (1)
Kain, Thomas M., 403 Cooper st., Camden (4)
Kain, Wm. W., Cape May C't Hs., R.F.D. No.1 (4)
Kain, Charles J., 349 Grand st., Paterson (16)
Kane, Chas. J., 349 Grand st., Paterson (16)
Kapp, Carl G., 410 Westminster av., Elizabeth (20)
Karshmer, Nathan, 422 George st., New Bruns. (12)
Kastler, F., Rutherford (2)
Kauffman, Louis J., Millville (6)
Kaufhold, Frank, 41 Leslie st., Newark (7)
Kaufman, Jerome G., 299 Clinton av., Newark (7)
Kaufman, M. J., 103 Lyons av., Newark (7)
Kavanaugh, D. E., 252 Washington av., Bellev'le(7)
Kay, Clarence R., Peapack (18)
Kazmann, Harold A., 406 Broadway, L. Branch(13)
Kearney, Edward P., 26 Forest st., Montclair (7)
Kearney, John V., 410 Bergenline av., W. N. Y. (9)
Keating, C. A., 177 Ellison st., Paterson (16)
Keegan, Thos. D., 76 Bentley av., Jersey City (9)
Keeney, C. B., 137 Summit av., Summit (20)
Keim, Wm. F., 25 Roseville av., Newark (7)
Keir, Floyd E., Englewood (2)
Keller, F. J., 795 Broadway, Paterson (16)
Keller, Sidney C., 31 Lincoln Park, Newark (7)
Kelley, Chas. B., Tr. Co. of N. J. Bldg., Jer. C'y (9)
Kelly, Bernard S., 1954 Boulevard, Jersey City (9)
Kelly, James E., 160 Wegman Pkwy., Jersey City(9)
Kemeny, Imre, 48 Pulaski av., Carteret (12)
Kennedy, P. A., Englewood (2)
Kennedy, William M., Essex Co. San., Verona (7)
Kenney, J. A., 132 W. Kinney st., Newark (7)
Kenyon, H. M., Bergenfield (2)
Keppler, Charles, Jr., 723 Allwood rd., Clifton (16)
Kerdasha, Geo. W., 131 31st st., No. Bergen (9)
Kern, E. Clarence, 45 Park st., Montclair (7)
Kerns, Francis J., 556 Warren st., Newark (7)
Kessell, J. S., 643 Central av., East Orange (7)
Kessler, H. H., 31 Lincoln Park, Newark (7)
Kessler, Henry B., 666 Clinton av., Newark (7)
*Kice, Henry W., Dover (14)
Kiely, Eugene M., 926 Hudson st., Hoboken (9)
Kilduffe, Robert A., 5003 Atlantic av., Ventnor (1)
Kim, Gay Bong, 528 Totowa rd., Totowa (16)
Kinch, F. A., 267 E. Broad st., Westfield (20)
King, Alden P., Dover (14)
King, Chester A., Oradell (2)
King, Geo. W., Hud. Co. Hos. for Ins., Secaucus(9)
Kingslow, G. L., Hackensack (2)
Kinney, A. G., 917 Haddon av., Collingswood (4)
Kinney, Burton O., 41 Lincoln av., Little Falls (16)
Kinney, Seldon T., 250 Main st., South Amboy (12)
Kirkby, Cyril S., 98 Broad st., Bloomfield (7)
Kirkman, Leroy G., 176 Roseville av., Newark (7)
Kirkwood, Allan S., 53 Union st., Montclair (7)
Klaus, Henry, 435 Palisade av., Union City (9)
Kleiber, Estelle, 139 New st., New Brunswick (12)
Klein, Edward C., Jr., 209 Littleton av., Newark(7)
Klein, Edward F., 136 Market st., Perth Amboy(12)
Klein, William, 85 Bayard st., New Brnuswick (12)
Kleiner, Samuel, 162 Hamilton av., Paterson (16)
Klenk, J. P., 328 Belleville av., Bloomfield (7)
Kler, J. H., Rutgers Univ. Infirmary, N. Bruns. (12)
Kline, Herman, 2627 Pacific av., Atlantic City (1)
Kline, Oram R., 414 Cooper st., Camden (4)
Klugman, Louis W., 375 Ave. C, Bayonne (9)
Knapp, Richard E., Hackensack (2)
Knapp, Victor, 1005 Grand av., Asbury Park (13)
Knauer, George, 930 Elizabeth av., Elizabeth (20)
Knepper, Orcena F., 149 Crescent av., Plainfield(20)
Knight, Augustus S., Far Hills (18)
Knight, I. Warner, Pitman (8)
Knowles, G. M., Hackensack (2)
Knowles, James S., Millville (6)
Knox, C. A., Ridgefield Park (2)
Knox, Harriet L., Hackensack (2)
Knox, Howard A., High Bridge (10)
Koelsch, F. J., 14 Kirkpatrick st., N. Br'nsw'k (12)
Kolb, J. M., 725 10th st., Union City (9)
Kolodin, A., 147 Franklin st., Bloomfield (7)
Konzelman, Henry J., 50 King st., Hillside (20)
Kooperman, Barnett, 432 16th st., W. New York(9)
Kooperstein, Samuel, 395 Ogden av., Jersey City (9)
Koplin, Nathan H., 142 W. State st., Trenton (11)
Koppel, Joseph, 921 Bergen av., Jersey City (9)
Koppel, Leo A., 921 Bergen av., Jersey City (9)
Kossman, W. J., Long Valley (14)
Kovarsky, A. E., 255 State st., Perth Amboy (12)
Kowalski, Louis J., Burlington (3)
Kraczyk, M. J., 207 Whitehead av., South River (12)
Kraemer, Manfred, 186 Clinton av., Newark (7)
Kraissel, C., Englewood (2)
Kraker, David A., 31 Lincoln Park, Newark (7)
Kramer, S. E., 121 Market st., Perth Amboy (12)
Krans, Edw. S., 920 Park av., Plainfield (20)
Kraus, Clara M. DeH., Park av., Plainfield (20)
Krauss, Emory, Phillipsburg (21)
Krauss, Fletcher L., Chatham (14)
Krechmer, Abraham, 521 Pacific av., Atl. City (1)
Kresch, Philip, 42 W. 22nd st., Bayonne (9)
Krentz, Paul J., 363 Union av., Elizabeth (20)
Krohn, Mare, Church Blvd., Keansburg (13)
Kroll, Adolph, Jr., 103 Van Buren st., Passaic (16)
Krone, W. F., 31 Lincoln Park, Newark (7)
Kruger, William, 31 Lincoln Park, Newark (7)
Kuhlmann, Alvin E., 527 37th st., Union City (9)
Kuite, George B., Morris Plains (14)
Kummel, M., 31 Lincoln Park, Newark (7)
Kushner, Alexander, 48 Jacques av., Rahway (20)
Kutner, Chas., 1005 S .5th st., Camden (4)
Kuder, Joseph M., Mt. Holly (3)
Kuhl, John P., High st., Butler (16)
*Kuhl, Paul E., 48 N. Clinton av., Trenton (11)
Kustrup, J. F., 1435 S. Broad st., Trenton (11)

ASSOCIATE MEMBERS

Katzin, Eugene M., 50 Baldwin av., Newark (7)
Keen, W. W., 1729 Chestnut st., Philadelphia, Pa.(6)
Kenyon, Thomas A., 14 4th st., Weehawken (9)
Kimmel, Charles, 10 Johnson av., Newark (7)
Kimmel, M. Leonard 142 Manhattan av., Jer. C'y(9)
Kingsbury, Marguerite, 207 Summer av., Newark(7)
Klein, Alexander, 210 Market st., Perth Amboy(12)
Klein, Alexander, 961 S. Broad st., Trenton (11)
Klein, Allan, 5580 Hudson Blvd., N. Bergen (9)
Klemmer, Paul, 414 Market st., Trenton (11)
Kondor, Joseph, 978 S. Broad st., Trenton (11)
Kraemer, Samuel H., 309 Baldwin av., Jersey C'y(9)
Kuch, Edward, 991 S. Broad st., Trenton (11)

ACTIVE MEMBERS

Laauwe, H. W., 198 Haledon av., Paterson (16)
Labash, Charles, 83 Quincy st., Passaic (16)
Labow, Joseph T., 1063 E. Jersey st., Elizabeth (20)
Ladas, George, 305 Cherry st., Elizabeth (20)
Lafferty, Elton B., 328 Myrtle av., Irvington (7)
Laird, George S., 127 Central av., Westfield (20)
Lamberto, V. A., 422 Stuyvesant av., Lyndhurst(2)

Lance, E. W., 93 W. Milton av., Rahway (20)
Landaw, Louis, 583 Broadway, Paterson (16)
Landis, Edwin W., Stillwater (19)
Lane, A. G., Greystone Park (14)
Lane, Austin W., 98 Prospect st., East Orange (7)
Lane, E. W., Bloomsbury (10)
Lane, Frank B., 53 Woodland av., East Orange (7)
Lange, Louis C., 50 Clifton ter., Weehawken (9)
Lansing, T. B., Tenafly (2)
Largay, Arthur O., 937 Ave. C, Bayonne (9)
Larkey, Charles J., 700 Ave. C, Bayonne (9)
Larossa, Ernest A., 701 Cooper st., Camden (4)
La Riew, Fred J., Washington (21)
Larrabee, C. H., 30 Beechwood rd., Summit (20)
Larson, Henry M., 36 Franklin st., Morristown (14)
Lathrop, Frederick W., 507 Park av., Plainfield (20)
Laurie, Andrew L., 664 Newark av., Elizabeth (20)
Lavine, Barney D., 630 N. Clinton av., Trenton (11)
Lawrence, Elias D., Paterson (16)
Lawrence, Wm. H., Jr., 129 Summit av.,Summit(20)
Lawsing, G. Condi, 443 22nd st., West New York (9)
Lawton, Anderson A., Somerville (18)
Leavitt, John F., 522 N. Third st., Camden (4)
Le Bel, Louis J. B., 165 Grant av., Nutley (7)
Lee, Stephen G., 55 Halsted st., East Orange (7)
Lee, Thomas B., 622 Cooper st., Camden (4)
Le Favor, Dean H., Palmyra (3)
Lefkowitz, Jacob H., 445 20th st., W. New York (9)
Legato, S., Cliffside (2)
Leggett, Thos. H., Jr., 937 Oakland pl., Plainf'ld(20)
Lehman, Irving J., 558 Central av., Newark (7)
Leighton, Robt. L., 401 Ludlow av., Spring Lake(13)
Leining, Albert, 1 Fourth st., Weehawken (9)
Leir, J. Krevin, 9 Garrison av., Jersey City (9)
Lemacher, Frank, Lakewood (15)
Lemmerz, Theodore H., 141 Magnolia av., Jer.C'y(9)
Leonard, E. A., 771 Madison av., Paterson (16)
Leonard, Geo. F., 65 N. 5th av., New Brunswick (12)
Leonard, Isaac E., 2842 Atlantic av., Atl. City (1)
Leonard, Lothair L., 615 Asbury av., Asbury P'k(13)
Leonardis, Jas. V., 94 Jefferson st., Newark (7)
Lerman, Irving, 1024 E. Jersey st., Elizabeth (20)
Lesko, S. W., Wallington (2)
Lettiere, A. J., 320 Centre st., Trenton (11)
Levendusky, D. E., 52 Market st., Passaic (16)
Levin, Louis, 140 W. State st., Trenton (11)
Levin, M. L., 326 Avon av., Newark (7)
Levine, D. B., 147 Broadway, Paterson (16)
Levine, G. I., 2107 Boulevard, Jersey City (9)
Levine, Sidney C., 459 Park av.&30th st.,Pat'rs'n(16)
Levinsohn, S. A., 584 Broadway, Paterson (16)
Levinson, L. J., 18 Stratford pl., Newark (7)
Levitas, George M., Westwood (2)
Levitt, Jesse N., 26 Clinton pl., Newark (7)
Levy, A., Somerville (18)
Levy, Julius, 66 Baldwin av., Newark (7)
Lewis, Albert, 41 Retford av., Cranford (20)
Lewis, Alice B., Saddle River (2)
Lewis, Geo. R., 458 Washington av., Belleville (7)
Lewis, Leon, 190 Clinton av., Newark (7)
Lewis, Livingston L., 712 Wash'gt'n st., Hobok'n(9)
Lewis, Thos. K., 47 S. 27th st., Camden (4)
Leyenberger, S. B., 319 Mt. Prospect av., Newark(7)
Liccese, Emanuel, 635 Summer av., Newark (7)
Lieberman, David P., 1072 North av., Elizabeth (20)
Lieberman, Milton L., 101 Union av., Roselle P'k(20)
Lilien, M. M., 162 Gruman av., Hillside (20)
Linares, A. C., 208 Market st., Paterson (16)
Linden, Mortimer H., 45 Clendenny av., Jer. C'y (9)
Lindroth, Lawrence V., 4633H'ds'n Blvd.,N. B'rg'n(9)
Linke, Julian P., 245 E. Front st., Plainfield (20)
Lipphard, Alvin T., 682 Stuyvesant av., Irvington(7)
Lippincott, A. Haines, 406 Cooper st., Camden (4)
Littie, William R., 493 W. State st., Trenton (11)
Littwin, Charles, Englewood (2)
Liva, Arcangelo, 5 Pangborn pl., Hackensack (2)
Liva, P. F., Lyndhurst (2)
Livengood, B. A., Swedesboro (8)
Livengood, Horace R., 587 Westminster av.,Eliz.(20)
Livingston, Paul, 299 Main st., East Orange (7)
Lloyd, Reba (Krump), Bridgeton (6)
Loder, Horace B., Bridgeton (6)
Loder, Joseph S., 924 S. 17th st., Newark (7)
Loeser, Lewis Henry, 31 Lincoln Park, Newark (7)
Lomauro, Jas. R., 73 Gron st., Passaic (16)
London, William M., 255 State st., Perth Amboy(12)
Londrigan, Jos. F., 535 Washington st., Hoboken (9)
Long, Herbert W., 102 Jefferson st., Newark (7)
Long, Miles T., 2150 Boulevard, Jersey City (9)
Long, Pauline A., 20 Liv'gst'n av., N. Br'nsw'k (12)
Long, William H., Somerville (18)
Longbothum, Geo. T., 208 Dunellen av., Dunell'n(12)
Longsdorf, Harold E., Mt. Holly (3)
Loper, John G., Bridgeton (6)
Lore, Harry E., Bridgeton (6)
Lorenzo, M. J., 64-A Bridge av., Red Bank (13)
Losada, Camelia A., 19 Prospect st., Summit (20)
Lottridge, Dorothy, 43 S. Maple av., E. Orange (7)
Love, Elizabeth F., Morrestown (3)
Lovejoy, J., Bound Brook (18)
Lovell, Frederick H., 1013 Clinton av., Irvington (7)
Lovell, John F., 1011 Clinton av., Irvington (7)
Lovett, Irving K., 100 E. Front st., Red Bank (13)
Lovett, Jos. C., Municipal Hospital, Camden (4)
Low, Donald B., 529 Broadway, Paterson (16)
Lowell, M. E., 434 Summit av., Westfield (20)
Lowenstein, H. A., 96 Milford av., Newark (7)
Lowrey, Jas. H., 79 Congress st., Newark (7)
Lowy, Otto, 190 Clinton av., Newark (7)
Luban, Benjamin, 730 High st., Newark (7)
Lucas, Henry H., 266 Van Houten st., Paterson (16)
Lucas, Stanley L., 1600 Arctic av., Atlantic City (1)
Lucas, W. Fred, Burlington (3)
Lucent, S. Bell, 48 Main st., Little Falls (16)
Luczynski, Edw. L., 38 W. 26th st., Bayonne (9)
Luediecke, Rowland E., E. Rutherford (2)
Luffburrow, C. B., 441 W. Front st., Plainfield (20)
Luippold, E. J., 85 Columbia ter., Weehawken (9)
Lukats, E. J., Skillman (18)
Lummis, C. Percy, Bridgeton (6)
Lummis, M. F., Pitman (8)
Lund, John L., 267 High st., Perth Amboy (12)
Lundblad, Walt. E., 75 Prospect st., E. Orange (7)
Lupin, Edward E., 727 Ave. C, Bayonne (9)
Lurie, Sol I., 21 Hillside av., Newark (7)
Lyerly, J. M., 1116 Putman av., Plainfield (20)
Lyneh, A. E. O., 257 Orange rd., Montclair (7)
Lynch, Edward Thos., 748 Livingston rd., Eliz. (20)
Lynch, M. M., Hackensack (2)
Lynch, Roland J., 93 Fairview av., Jersey City (9)
*Lynn, J. V., Ridgefield (2)
Lyon, Archibald, 115 Ridge rd., Arlington (7)
Lyon, C. H., Phillipsburg (21)
Lyon, Earl C., Bridgeton (6)
Lyon, Leslie C., P. O. Box 63, Magnolia (4)
Lyons, James V., 333 Park av., Orange (7)
Lyons, R., Englewood (2)

ASSOCIATE MEMBERS

Landshof, Chas. A., 50 Glenwood av., Jer. City (9)
Lazow, S. M., Broad st., Matawan (12)
Lee, John J., 66 Central av., Orange (7)
Lesh, Vincent O., 114 S. Stevens av., So. Amboy(12)
Lewis, Leon, 190 Clinton av., Newark (7)
Liccese, Emanuel, 635 Summer av., Newark (7)
Licks, Frederick C., 63 Taylor pl., So. Orange (7)
Liddy, F. J., Mahwah (2)
Lief, Lawrence H., Jamesburg (12)
Lipshutz, Chas., 804 Ave. C, Bayonne (9)

Lobban, Robert B., 2595 Boulevard, Jersey City (9)
Lynn, Irving I., 2554 Boulevard, Jersey City (9)

ACTIVE MEMBERS

Maas, Max A., 329 Clinton av., Newark (7)
Mabey, J. Corwin, 242 Claremont av., Montclair (7)
MacAlister, Wm. W., 333 VanHouten st.,P't'rs'n(16)
Macalister, Alexander, 626 Federal st., Camden (4)
MacAlpine, K. B., 308 Monmouth st., Gl'c'st'r C'y (4)
MacArthur, Clymont, 219 Roseville av., Newark (7)
Macaulay, F. A., 815 Elm av., Teaneck (2)
Macchia, Benj. J., 262 Montgomery st., Jer. City (9)
MacDermid, L. E., 506 Farnsworth av.,Bord'nt'n(11)
Macdonald, W. S. 56 Church st., Montclair (7)
MacDowell, J. L., 113 Market st., Perth Amboy (12)
Mace, Margaret, North Wildwood (5)
MacFarland, Burr W., Broad St.Bk.Bldg.,Tr'nt'n(11)
Mackellar, James M., Tenafly (2)
MacKenzie, R. A., 501 Grand av., Asbury Park (13)
Mackes, C. L., Woodstown (17)
Mackler, Louis, 705 Pacific av., Atlantic City (1)
Maclay, Joseph A., 181 E. 33rd st., Paterson (16)
MacMillan, Wright, 23 Passaic av., Passaic (16)
MacPherson, Elwood H., 12 Rawley pl., Millburn(7)
Madden, Leland S., 21 E. Verona av., Pleasantv'le(1)
Madden, T. W., 16 Frazier av., Collingswood (4)
Madden, Wm. L., 83 Gifford av., Jersey City (9)
Mader, A. I., Hackensack (2)
Magennis, Bryan C., 170 Hamilton av., Paterson(16)
Maggio, Geo. A., 110 Fleming av., Newark (7)
Maggio, Ross J., 200 Ross pl., Westfield (20)
Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
Magovern, Thomas, 226 S. Orange av.,So.Orange(7)
Mahaffey, Jesse L., 414 Cooper st., Camden (4)
Maher, John E., 90 Third av., Long Branch (13)
Mahood, H. L., 86 Durand rd., Maplewood (7)
Majeski, H. J., 1015 Brunswick av., Trenton (11)
Major, Morton, 1710 Pacific av., Atlantic City (1)
Makin, John B., 501 Grand av., Asbury Park (13)
Malatesta, C. S., 741 Kingston av., Plainfield (20)
Malavazos, Antonio, 635 High st., Newark (7)
Maldeis, A. M. K., 117 North 6th st., Camden (4)
Maliniak, Jacques W., 1125 Park av., N. Y. City (7)
Mallalieu, Frank W., 16 Monticello av., Jer. City(9)
Maloney, L. F., 156 2nd st., Clifton (16)
Mamlet, Alfred M., 16 Johnson av., Newark (7)
Mancusi-Ungaro, E., 270 Mt. Prosp. av., Newark(7)
Mancusi-Ungaro, L., 156 Mt. Prosp. av., Newark (7)
Mangone, Geo. F., 171 Palisade av., Union City (9)
Manly, Thos. E., 390 Park av., Paterson (16)
Mann, Jacob J., 255 State st., Perth Amboy (12)
Maps, Howard L., 53 Passaic av., Passaic (16)
Maras, Peter E., 80 Tonnele av., Jersey City (9)
Marcarian, Henry B., 904 Cooper st., Camden (4)
Marcus, Alexander, 55 Oxford st., Newark (7)
Marcus, Joseph H., 1148 Fifth av., N. Y. C., N.Y.(1)
*Marcy, Alexander, Jr., Riverton (3)
Marcy, John W., 117 E. Park av., Merchantville(4)
*Margulis, B. N., Newark (7)
Marini, D., 40 Henry st., Passaic (16)
Mark, Joseph, 102 Green st., Woodbridge (12)
Markley, L. A., Teaneck (2)
Markowitz, B. B., 2157 Boulevard, Jerscy City (9)
Markowitz, Irwin, 2157 Boulevard, Jersey City (9)
Markowitz, Louis, 16 Church st., Paterson (16)
Marks, David M., 298 4th st., Jersey City (9)
Marks, Edward G., 655 Kearny av., Arlington (7)
Marotte, Chas. L., 1417 S. Clinton av., Trenton (11)
Marquis, Dean W., 144 Harrison st., E. Orange (7)
Marquis, W. James, 198 Clinton av., Newark (7)
Marrocco, Wm., 261 Park av., Paterson (16)
Marsh, Elias J., 400 Van Houten st., Paterson (16)
Marshak, Martin I., 679 Ave. C, Bayonne (9)
Marshall, Jos. C., 1517 Pacific av., Atlantic City (1)
Martin, E. L., 293 Nassau st., Princeton (11)
Martin, William, Hotel Ambassador, Atl. City (1)
Martin, Wm. P., 25 Holland rd., South Orange (7)
Martinetti, Carlo D., 311 Central av., Orange (7)
Martland, Harrison S., 180 Clinton av., Newark (7)
Marvel, Philip, Jr., 101 S. Indiana av., Atl. City (1)
Marvin, Dorothy, 51 Livingston av., N. Br'nsw'k(12)
Mason, Howard B., 90 W. Main st., Freehold (13)
Mason, James H., 3d., 1616 Pacific av., Atl. City(1)
Massey, J. B., New Brunswick (18)
Massey, John F., 20 S. Newport av., Ventnor (1)
Masucci, A., 34 Ward st., Paterson (16)
Matera, Joseph, 506 Garden st., Hoboken (9)
Mathesheimer, J. L., 280 Old Bergen rd., Jer. C'y(9)
Matheke, O. G., 328 Sussex av., Newark (7)
Matheson, G. E., 649 Central av., East Orange (7)
Mathews, R., Morristown (14)
Mathews, William, 65 Broad st., Red Bank (13)
Matthew, H. E., 504 Hillside av., Orange (7)
Matthews, W. F., 11 Seymour av., Montclair (7)
Matthews, Wm. J., 938 Hudson st., Hoboken (9)
Mayer, Wm. W., 532 Bergen av., Jersey City (9)
May, Ernst A., 965 Broad st., Newark (7)
Mayhew, Charles H., Millville (6)
McBride, Andrew F., 30 Church st., Paterson (16)
McBride, Hesser G., 1072 S. Orange av., Newark (7)
McCabe, Thos. S., 913 Broad st., Newark (7)
McCall, Jesse, Newton (19)
McCallion, W. H., 722 Westm'ster av., Elizabeth(20)
McCamey, Kenneth E., 174 Carroll st., Paterson (16)
McCandliss, W. K., State Hospital, Trenton (11)
McCarthy, Arthur M., 2772 Federal st., Camden (4)
McCauley, Francis J., 31 Lincoln Park, Newark (7)
McClintoch, Elsie, 1435 Maple av., Hillside (20)
McCallum, A. S., 213 Clem'ts Br. rd., Barrington (4)
McConaghy, T. P., cor. 10th & Cooper st.,Camden(4)
McConaughy, Francis, Somerville (18)
McComack, F. C., Englewood (2)
McCormick, Jas. E., 322 Clinton av., Newark (7)
McCormick, Wm. H., 266 Market st., P. Amboy (12)
McCoy, John C., 292 Broadway, Paterson (16)
McCroskery, Jas. H., 396 N. Arl'gton av., E. Or. (7)
McCullough, John H., 523 E. State st., Trenton (11)
McDede, Frank F., 922 Main st., Paterson (16)
McDede, J. Searle, 215 Ege av., Jersey City (9)
McDermoit, Vincent, 511 State st., Camden (4)
McDonald, F. R., 79 Summit av., Jersey City (9)
*McDonald, John O., 194 W. State st., Trenton (11)
McDonald, R. J., 294 Broadway, Paterson (16)
McDonnell, Gerald E., Mt. Holly (3)
McElhinney, Dennis R., 110 W.Jer.st., Elizab'th(20)
McElroy, Ervin, Rockaway (14)
McEwen, Floy, 299 Broadway, Newark (7)
McFeeley, P. R., Bogota (2)
McGinn, W. J., Westfield av., Fanwood (20)
McGlade, Thos. H., Cam. Co. Hosp., Lakeland (4)
McGovern, John F., 24 Liv'ston av., N. Bruns. (12)
McGuigan, F. A., 212 N. Warren st., Trenton (11)
McGuire, Jas. J., 122 W. State st., Trenton (11)
McIlvaino, W. E., Ridgefield Park (2)
McKiernan, Robt. L., 97 Bayard st., N. Bruns. (12)
McKim, William F., 1044 S. Orange av., Newark (7)
McKinstrey, J. W., Jamesburg (12)
McLane, A. D., Englewood (2)
McLean, Herbert E., 92 Fairview av., Jer. City (9)
McLean, Hugh A., 414 17th st., West New York (9)
McLellan, Geo. A., 19 Hawthorne av., E. Or. (7)
McLeod, H. J., Englewood (2)
McLeod, N. S., Raritan av., New Brunswick (12)
McLoughlin, Frank J., 558 Jer. av., Jersey City (9)
McMurtrie, William A., Hackettstown (21)
McPherson, M. E., 171 Diam'd Bdg.av.,Hawth'ne(16)
McVay, Edward A., 234 Lafayette st., Newark (7)
McVeigh, Charles, Stanhope (19)

Meacham, Eugene A., 112 Stevens av., S. Amb.(12)
Mead, Walter G., 699 Kearny av., Arlington (9)
Means, P. B., State Hospital, Trenton (11)
Mears, W. G., Leonia (2)
Mecray, Paul M., 405 Cooper st., Camden (4)
Medd, John C., 25 Curtis pl., Maplewood (7)
Meehan, Geo. Edw., 117 Mercer st., Jersey City (9)
Meehan, Martin M., 201 Joralemon st., Belleville(7)
Meeker, Frank B., 355 Clifton av., Newark (7)
Meeker, Irving A., 581 Valley rd., Up. Monte'r (7)
Meigh, Josiah, Bernardsville (18)
Meinzer, Martin S., 147 Market st., P. Amboy (12)
Mellen, S. H., 863 Mt. Prospect av., Newark (7)
Meloney, Lester F., 156 2nd st., Clifton (16)
Meltsner, L., 904 Hudson st., Hoboken (9)
Mendelsohn, D. H., 576 Broadway, Paterson (16)
Mendelsohn, Lewis, 272 Montgomery st., Jer. City(9)
Mendenhall, Clinton D., Bordentown (3)
Meneve, A., 87 Bridge st., Paterson (16)
Mengel, Willard G., 400 Penn st., Camden (4)
Menk, Paul E., 31 Lincoln Park, Newark (7)
Merendino, A. G., 1616 Pacific av., Atlantic City (1)
Merliss, Eugene, 386 Clinton av., Newark (7)
Merlo, Francis A., 500 E. Jersey st., Elizabeth (20)
Merrill, C. F., 16 N. 3d av., Highland Park (12)
Mersclis, John G., 110 Irvington av., S. Orange (7)
Mersheimer, Chris. H., 15 Reserv'r av., Jer.City (9)
Messinger, Sam. J., 31 Roosevelt av., Carteret (12)
Metzer, Emma P. W., Riverside (3)
Meurlin, Alfred, 158 Harrison st., East Orange (7)
MeVay, James C., 2907 Pacific av., Atlantic City(1)
Mewborne, Edw. B., Lawrenceville (11)
Meyer, Eugene A., Moorestown (3)
Meyer, George P., 410 Haddon av., Camden (4)
Meyer, H. M., Hackensack (2)
Meyer, Wm., 436 New York av., Union City (9)
Meyers, F. R., 326 Park av., Paterson (16)
Mial, Leonidas L., 38 Elm st., Morristown (14)
Michell, George, 221 High st., Hackettstown (14)
Mick, Edwin C., 54 Main st., Orange (7)
Miller, Earle K., 2502 Nottingham Way, Tr'nt'n (11)
Miller, G. H., N. Main st., Cranbury (11)
Miller, H. Garrett, Millville (6)
Miller, Jos. A., 364 Prospect st., S. Orange (7)
Miller, Louis H., Woodstown (17)
Miller, M. H., 311 16th st., West New York (9)
Miller, Robt. M., 382 Springfield av. Summit (20)
Miller, T. B., Butler (14)
Mills, Alvah V., Lindsley rd., Little Falls (16)
Mills, Charles S., Riverton (3)
Mills, Clifford, Morristown (14)
Mills, Stephen D., 132 S. Euclid av., Westfield (20)
Minard, E. L., 140 4th av., East Orange (7)
Miner, Donald, 921 Bergen av., Jersey City (9)
Minier, Carl L., 15 Lombardy st., Newark (7)
Minnefor, C. A., 126 Carolina av., Newark (7)
Minneila, Thos. J., 12 Russell pl., Summit (20)
Minningham, Wm. D., 18 Hedden ter., Newark (7)
Mintz, Abraham, 108 Treacy av., Newark (7)
Mishell, Daniel R., 730 Prospect st., Maplewood (7)
Missonellie, Wm., 404 Lafayette av., Hawth'ne (16)
Mitchell, August J., 59 South st., Newark (7)
Mitchell, Chas. H., 1100 W. State st., Trenton (11)
Mitchell, Charles R., 311 Broadway, Paterson (16)
Mitskas, T. V. J., Main st., Crosswicks (11)
Mockridge, O. A., 8 S. Mountain av., Montclair (7)
Moeckel, Clarence W., 34 Plymouth st., Montcl'r (7)
Moffatt, Barclay W., Nut Swamp rd., R. Bank (13)
Mohrbacher, J. J., 37 Osborne ter., Newark (7)
Moister, Roger W., 30 Beachwood rd., Summit (20)
Molitch, Matthew, Jamesburg (12)
Monaghan, W. J., Hud. Co. Hospital, Secaucus (9)
Monasson, Ida, Woodbine (5)
Montfort, R. J., 1051 E. Jersey st., Elizab'th (20)
Moore, John D., 6 Washington av., Bloomfield (7)
Moore, Ralph L., Woodbury (8)
Moran, H., Englewood (2)
Moress, Edward J., 1501 Maple av., Hillside (20)
Moriconi, A. F., 438 Hamilton av., Trenton (11)
Morgan, Browne, 260 Liberty st., Bloomfield (7)
Morley, Grace C., 440 Palisade av., Weehawken (9)
Morrill, James P., 310 Broadway, Paterson (16)
Morris, Carlyle, Metuchen (12)
Morris, Clement, 513 Broadway, Newark (7)
Morris, D. G., 11 W. 26th st., Bayonne (9)
Morris, Thos. M., 503 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Springfield (20)
Morris, B. G., Woodridge (2)
Morrison, Caldwell, 379 7th av., Newark (7)
Morrison, Frederick H., Newton (19)
Morrison, J. Bennett, 66 Milford av., Newark (7)
Morrone, John A., 233 Bowers st., Jersey City (9)
Morrow, J. R., Oradell, (2)
Moschkowitz, Herman, 739 High st., Newark (7)
Mosher, H. L., Lyndhurst (2)
Motzenbecker, P. F., 680 High st., Newark (7)
Motzenbecker, Wm., 16 Milford av., Newark (7)
Moulton, Chas. D., 122 Park av., East Orange (7)
Mount, Walter B., 21 Plymouth st., Montclair (7)
Mras, J. N., State Hospital, Trenton (11)
*Mravlag, Victor, 1064 E. Jersey st., Elizabeth (20)
Mueller, George H., 102 Summit av., Jer. City (9)
Muldoon, Edward J., Florence (3)
Mulford, Ephraim R., Burlington (3)
Muller, F. L., Carlstadt (2)
Mulligan, L. A., Leonia (2)
Mullin, Raymond J., 857 S. 11th st., Newark (7)
Munger, Ray T., 727 Watchung av., Plainfield (20)
Munro, Chas. A., Marlton (3)
Murn, Charles J., 48 Smith st., Paterson (16)
Murphy, Edward A., 1 Britton st., Jersey City (9)
Murphy, Herschel S., 320 Chestnut st., Ros'le (20)
Murphy, J. A., 467 Hamilton av., Trenton (11)
Murphy, James M., 2757 Boulevard, Jer. City (9)
Murphy, Leo J., 374 West st., Union City (9)
Murphy, P. H. W., 27 Jefferson av., Jer. City (9)
Murray, E. N., 601 Walnut st., Camden (4)
Murray, Harold A., 624 Mt. Prospect av., New'k (7)
Murray, Jos. A., 765 Ave. C, Bayonne (9)
Murray, Norman L., 129 Summit av., Summit (20)
Musetto, Carmelo A., Boonton (14)
Mustermann, Otto H., 303 48th st., Union City (9)
Muta, Samuel A., 47 Park av., West Orange (7)
Muttart, George W., 702 Ocean av., Jer. City (9)
Mutter, Alfred A., 75 Beech st., Kearny (9)
Myatt, Leslie E., Bridgeton (6)
Myerson, Noah, 428 15th st., West New York (9)

ASSOCIATE MEMBERS

Macaluso, D., 531 Joralemon st., Belleville (7)
Madison, Louis K., 358 Pacific av., Jersey City (9)
Marano, Michael A., 508 4th st., Union City (9)
Margulies, Chas., 203 Harrison av., Jersey City (9)
Massengill, F., 31 Clinton st., Newark (7)
Masterson, John F., 94 Myrtle av., Irvington (7)
Matthews, C. B., 709 Greenwood av., Trenton (11)
McCarthy, John J., 606 35th st., N. Bergen (9)
McLoughlin, John W., 39 W. 26th st., Bayonne (9)
Miller, Nathan, 990 Sanford av., Irvington (7)
Miller, Samuel R., 31 Main st., Pennington (11)
Morrow, Chas. S., 321 S. 9th st., Newark (7)
Mullin, Eugene P., 515 Sanford av., Newark (7)
Mulvihill, Wm. J., 275 Hudson Blvd., Bayonne (9)
Munro, Jeanette, 293 Nassau st., Princeton (11)

ACTIVE MEMBERS

Nafash, M., Shafesk, 402 21st st., Union City (9)
Nafey, H. W., 51 Livingston av., N. Brunsw'k (12)
Nalitt, David I., 28 W. 33rd st., Bayonne (9)
Nappi, P. E., 215 Mt. Prospect av., Newark (7)

*Nash, Albert B., 10 South 13th st., Newark (7)
Nash, Alexander E., 20 Forest av., Verona (7)
Nash, Herman S., 865 S. 11th st., Newark (7)
Nash, Wm. G., 20 Clinton st., Newark (7)
Nataro, Joseph, 172 Littleton av., Newark (7)
Nattrass, R. B., 204 11th st., Hoboken (9)
Naulty, Chas. W., 403 High st., P. Amboy (12)
Neal, Charles B., Millville (6)
Neare, Clifford B., 2 Hawthorne av., E. Orange (7)
Neer, William, 245 Broadway, Paterson (16)
Neiderhoffer, S. L., 469 Broadway, L. Branch (13)
Nemzek, Wm. P. B., 141 Ridge rd., Arlington (7)
Nesbit, Eliz. N. J. Tr'n'g School, Little Falls (16)
Netz, L. W., Hackensack (2)
Nevin, John, 131 Kensington av., Jersey City (9)
Newcomb, Marcus W., Browns Mills (3)
Newman, Abraham J., 70 Sherman pl., Jer. City (9)
Newman, Grace T., 339 Grove st., Montclair (7)
Newman, Julius, 10 Osborne ter., Newark (7)
Newman, Louis G., 316 E. Broad st., Westfield (20)
Nicol, L. C., Bogota (2)
Nichols, F. I., Hackensack (2)
Nichols, Stanley H., 501 Grand av., Asbury P'k (13)
Nicholson, Frank, 895 Summit av., Jersey City (9)
*Nicholson, J. L., 205 Washington av., Had'nf'd (4)
Nickman, Harrison, 101 S. Newton av., Atl. City (1)
Nieman, S. Z., 92 Bayard st., New Brunswick (12)
Niemtzow, Frank, 45 E. Main st., Freehold (13)
Nittoli, R. N., 660 E. Jersey st., Elizabeth (20)
Noll, Louis, 1044 Clinton av., Irvington (7)
North, Harry R., 160 W. State st., Trenton (11)
Norton, James F., 299 Varick st., Jersey City (9)
Notkin, Meyer, 351 Van Houten st., Paterson (16)
Nuse, Edward F., 50½ Jersey av., Jersey City (9)
Nye, Howard H., 174 Broadway, Paterson (16)
Nyiri, William, 30 Van Ness pl., Newark (7)

ASSOCIATE MEMBERS

Nacca, Carl A., 86 N. Essex av., Orange (7)
Nevius, Wm. B., 61 N. Fullerton av., E. Orange (7)
Noble, C. P., 1509 Locust st., Philadelphia, Pa. (6)
Nonziato, F. A., 50 Centre st., Trenton (11)

ACTIVE MEMBERS

Obert, J. E., New Egypt (15)
Obester, G. E., 617 Madison av., Elizabeth (20)
O'Brian, D. M., 162 Lexington av., Passaic (16)
O'Brien, Paul, Rutherford (2)
O'Brion, D. J., 197 Spring st., Portland, Maine (20)
Ockene, Abraham, 495 Palisade av., Union City (9)
O'Connor, B. A., 314 North 4th st., Harrison (9)
O'Connor, D. F., 671 Broad st., Newark (7)
O'Connor, J. J., 434 New York av., Union City (9)
O'Connor, M. J., 98 Shanley av., Newark (7)
O'Crowley, Clarence R., 31 Lincoln Pk., Newark (7)
Oestman, A. W., 932 Summit av., Jersey City (9)
O'Gorman, M. W., 880 Bergen av., Jersey City (9)
O'Hanlon, George, Medical Centre, Jersey City (9)
Okin, I., 23 Passaic av., Passaic (16)
Olcott, Geo. P., 144 Harrison st., East Orange (7)
Older, Benj., 435 New York av., Union City (9)
Oleynick, S., 107 Clinton av., Newark (7)
Olini, Joseph J., 30 W. Market st., Newark (7)
Oliver, David H., Bridgeton (6)
Olmstead, W. D., 515 Grammercy pl., Atl. City (1)
Olpp, A. E., 318 Bergenline av., Union City (9)
Ondovchak, M. F., King's h'w'y, Mt. Ephraim (4)
O'Neil, Chas. L., 11 N. 7th st., Newark (7)
O'Neill, John H., 270 Montgomery st., J. City (9)
Opdyke, C. P., 10 Summit rd., Verona (7)
Opdyke, George McC., 10 Summit rd., Verona (7)
Opdyke, L. A., 55 Clinton av., Jersey City (9)
Openchowski, M., 52 Jones st., Newark (7)
Opfermann, J. L., 167 Bay av., Highlands (13)
Oram, Joseph H., 495 Broadway, Paterson (16)
Orloff, Samuel, 97 Lyons av., Newark (7)
Ornaf, I. E., 1154 Thurman st., Camden (4)
O'Rourke, James J., 871 Stuyvesant av., Tr'nt'n (11)
Orton, Carlton B., 235 Chestnut st., Roselle (20)
Orton, George Lee, 98 Elm av., Rahway (20)
Orton, Henry B. 24 Commerce st., Newark (7)
Osborn, John W., 111 N. Parkway, East Orange (7)
O'Shea, John J., 135 Shippen st., Weehawken (9)
Oshrin, Henry, 750 Park av., West New York (9)
Osmun, Milton M., 611 Broadway, Camden (4)
Ovens, R. C., 675 Bergen av., Jersey City (9)
Owen, Logan S., 938 Hudson st., Hoboken (9)

ASSOCIATE MEMBERS

Ortolano, Jas., 522 Garden st., Hoboken (9)
O'Sullivan, John R., 288 Chestnut st., Kearny (9)

ACTIVE MEMBERS

Pacicco, Michele, 376 Monmouth st., Jersey City (9)
Paddock, Royce, 965 Broad st., Newark (7)
Pagliughi, John J., 401 18th st., Union City (9)
Pal, D. R., 32 Clark st., Paterson (16)
Pallen, C. deS., Rochelle Park (2)
Palm, Howard F., 614 N. 2nd st., Camden (4)
Palmer, Francis R., 27 Monroe st., Passaic (16)
Palmer, Gideon H., 28 Winans st., East Orange (7)
Palmer, H. S., 257 Mulberry st., Newark (7)
Panigrosso, L. B., Raritan (18)
Panitch, Wm., 352 Belmont av., Newark (7)
Pannell, Walter L., 7 Prospect st., E. Orange (7)
Pannullo, John N., 266 Van Buren st., Newark (7)
Pansy, Abraham A., 12 Jackson st., So. River (12)
Panteleone, Joseph, 504 Hamilton av., Trenton (11)
Parent, Sol., 924 S. 20th st., Newark (7)
Parisi, Anthony, 150 Hunterdon st., Newark (7)
Park, M. B., 360 Park av., Paterson (16)
Parker, H. Norton, 72 N. Clinton av., Trenton (11)
Parker, J. W., 175 Shrewsbury av., Red Bank (13)
Parker, John E., 385 Park av., Orange (7)
Parry, O. K., 601 Bangs av., Asbury Park (13)
Parsonnet, Eugene V., 31 Lincoln Pk. Newark (7)
Patti, F. A., Leonia (2)
Paul, G. A., 765 Lyons av., Irvington (7)
Paulsen, Arch'd M., 160 E. 7th st., Plainfield (20)
Pavia, John R., 365 Chancellor av., Newark (7)
Payawall, J. L., 170 Broadway, Paterson (16)
Payne Guy, Overbrook Hospital, Cedar Grove (7)
Payne, Joseph, Midland Park (2)
Peacock, Arthur B., Columbus (3)
Pearl, Sidney S., 815 Kilsyth rd., Elizabeth (20)
Pearlstein, Frank, 325 16th st., W. New York (9)
Pedeville, J., Palisades Park (2)
Pedrick, Charles D., Glassboro (8)
Pedrick, William W., Glassboro (8)
Peer, Lyndon A., 965 Broad st., Newark (7)
Pegau, Paul, Woodbury (8)
Pellarin, John D., 493 N. York av., Union City (9)
Pellet, T. L., Hamburg (19)
Pelusio, August N., 269 Carroll st., Paterson (16)
Pendexter, S. E., 11 S. Arlington av., E. Orange (7)
Pennington, A. W., 182 Roseville av., Newark (7)
Pennington, John, 101 S. Indiana av., Atl. City (1)
Pentel, Louis S., 307 16th st., West New York (9)
Perham, B. S., 199 Lorraine av., Up. Montclair (7)
Perham, R. G., Hasbrouck Heights (2)
Perkel, Louis L., 3263 Boulevard, Jersey City (9)
Perlberg, Harry J., 921 Bergen av., Jersey City (9)
Perrine, C. C., 500 River rd., Fair Haven (13)
Perry, Frank L., Woodstown (17)
Pessel, J. F., 224 W. State st., Trenton (11)
Peters, E. A. P., 394 Bergen av., Jersey City (9)

Peters, Richard C., 963 Park av., Plainfield (20)
Peterson, C. A., 921 Washington st., Hoboken (9)
Peterson, W. R., 224 W. State st., Trenton (11)
Petry, William, 109 Treacy av., Newark (7)
Pettit, H. H., Ridgewood (2)
Pettit, Herschel, Ocean City (5)
Phelan, W. F., 124 Chilton st., Elizabeth (20)
Phephs, J. E., 203 Park av., Paterson (16)
Philhower, Geo., B., 281 Grant av., Nutley (7)
Phillips, A. A., 68 West Market st., Newark (7)
Phillips, C. B., 891 Haddon av., Collingswood (4)
Phillips, R. H. C., 144 W. State st., Trenton (11)
Phillips, Walter, Englewood (2)
Pieper, H. C., 575 Cedar av., W. Long Branch (13)
Pierson, Carl L., 178 W. State st., Trenton (11)
Pierson, J. R., 224 W. State st., Trenton (11)
Pierson, Theodore A., Hopewell (11)
Pigott, Albert W., Skillman (18)
Pike, Charles E., 411 Newton st., Oaklyn (4)
Pilch, Arthur G., 1 Willard av., Bloomfield (7)
Pilkington, Albert, Amsterdam apts., Atl. City (1)
Pinckey, Frank H., Morristown (14)
Pindar, A. W., Teaneck (2)
Pindar, Fred S., 960 Park av., N. Bergen (9)
Pindar, I. D., Teaneck (2)
Pindar, Wm. A., 975 Broadway, Woodcliffe (9)
Pinkerton, Wm. A., 854 Ave. C, Bayonne (9)
Pinneo, F. W., 439 Mt. Prospect av., Newark (7)
Pino, Anthony, Bridgeton (6)
Pinsky, Mordecai M., 944 S. 5th st., Camden (4)
Piskorski, Abdon V., 604 Jersey av., Jer. City (9)
Pittz, Geo. F., 152 25th st., Guttenberg (9)
Pizzi, Francis W., 205 Park av., Orange (7)
Plain, Irving H., 2 Stratford pl., Newark (7)
Plant, J. S., 467 High st., Newark (7)
Plante, Amos A., 228 Dunnell rd., Maplewood (7)
Platt, T. H., 307 N. Washington st., Dunellen (12)
Plavin, Nathan J., 5407 Hudson blvd., N. Berg'n (9)
Plinke, Fritz, 159 Lexington av., Passaic (16)
Plume, Clarence A., Succasunna (14)
Podell, Alfred, 51 E. Front st., Red Bank (13)
Pogoliff, Samuel H., Manville (18)
Poland, Geo. A., 206 Verona av., Pleasantville (1)
Poland, Joseph. 1904 Pacific av., Atlantic City (1)
Polevski, J., 682 High st., Newark (7)
Pollak, B. S., Hud. Co. Tub. San., Secaucus (9)
Pollis, Nicholas, 562 High st., Newark (7)
Polow, Benjamin, 318 Hawthorne av., Newark (7)
Polowe, David, 558 E. 27th st., Paterson (16)
Pomeranz, R., 31 Lincoln Park, Newark (7)
Pons, C. A., 501 Grand av., Asbury Park (13)
*Pooley, Thomas R., Jr., Newton (19)
Potter, Benj. Paul, Hud. Co. Tub. San., Sec'c's (9)
Potter, Ellen C., 301 W. State st., Trenton (11)
Potter, Raymond T., 144 Harrison st., E. Orange (7)
Pottinger, W., Mountain Lakes (14)
Povalski, Alex W., 1925 Boulevard, Jer. City (9)
Powis, Ethel M., 198 W. State st., Trenton (11)
Poyas, M. L., 1871 Pennington rd., Trenton (11)
Prather, C. G., Westwood (2)
Prather, J. W., Dumont (2)
Pratt, Arthur C., 516 Cooper st., Camden (4)
Pratt, William H., 516 Cooper st., Camden (4)
Pregnall, James P., 501 Grand av., Asbury Pk. (13)
Preston, Perry B., 12 Palm st., Newark (7)
Price, Nathaniel G., 31 Lincoln Park, Newark (7)
Prigger, E. R., Pennsgrove (17)
Primas, Howard E., 772 Pine st., Camden (4)
Prince, Robert A., 272 Park av., Paterson (16)
Principato, Roberto, 402 Walnut st., Camden (4)
Pringle, F. A., 192 Claremont av., Montclair (7)
Proctor, F. E., 1245 Greenwood av., Trenton (11)
Proctor, James Wm., Englewood (2)
Protzman, T. B., Englewood (2)
Proudfoot, P. A., 220 Chestnut st., Roselle (20)
Prout, Charles, 406 6th av., Asbury Park (13)
Prout, Thos. P., 19 Prospect st., Summit (20)
Prout, Wm. B., West Englewood (2)
Pudney, W. R., 11 Seymour st., Montclair (7)
Pullen, G. F., Leonia (2)
Purcell, Ernest F., 800 Stuyvesant av., Trenton (11)
Purdy, Chas. H., 35 Highland av., Jersey City (9)
Pursell, William Dana, Phillipsburg (21)
Pyle, Louis A., 89 Fairview av., Jersey City (9)
Pyle, Wallace, 15 Exchange pl., Jersey City (9)

ASSOCIATE MEMBERS

Paschal, G. W., Jr., 195 W. Main st., Milltown (12)
Pattyson, R. A., 144 Harrison st., East Orange (7)
Paul, H. Carl, 24 Hanford pl., Caldwell (7)
Payawall, J. L., Ramsey (2)
Payne, Guy, Jr., 9 So. Prospect st., Verona (7)
Pellicane, A. J., 185 Livingston av., N. Br'sw'k (12)
Penchansky, Samuel, 847 Ave. C, Bayonne (9)
Pilloni, Louis, 27 Park pl., Bloomfield (7)
Pinnerman, R. B., Bordentown av., S. Amboy (12)

DENTAL ASSOCIATE MEMBER

Phillips, C. F., D.D.S., 1509 Pacific av., Atl. City (1)

ACTIVE MEMBERS

Quigley, Frederic J., 4622 Boulevard, Union City (9)
Quinby, Wm. O'Gorman, 14 James st., Newark (7)
Quinn, John J., 707 Bergen av., Jersey City (9)
Quinn, Norman J., 3303 Pacific av., Atl. City (1)
Quinn, Stephen T., 326 S. Broad st., Elizabeth (20)
Quirk, Martin A., 104 Maple av., Red Bank (13)

ASSOCIATE MEMBER

Quad, Clifford W., 53 Northfield av., W. Orange (7)

ACTIVE MEMBERS

Radding, M. B., 321 Elmora av., Elizabeth (20)
Rado, William, 190 Clinton av., Newark (7)
Rados, Andrew, 299 Clinton av., Newark (7)
Ragany, Joseph, 966 S. Broad st., Trenton (11)
Rainey, W. G., 34 Bayard lane, Princeton (11)
Ramos, Nicholas J., 188 Market st., Newark (7)
Ramsey, F. Muriel, Millville (6)
Randall, Chas. H., 50 3rd av., Newark (7)
Randolph, John M., 131 Main st., Rahway (20)
Ranson, B. B. J., 601 Ridgewood av., Maplew'd (7)
Rathbone, T. J., 129 Summit av., Summit (20)
Rathgeber, C. F., 18 William st., E. Orange (7)
Rathgeber, Wm. M., 249 Roseville av., Newark (7)
Raughley, Wm. C., Taunton av., Berlin (4)
Ravitz, S. F., 1143 Broad st., Newark (7)
Rawitz, Sidney B., 42 Chancellor av., Newark (7)
Read, Jessie D., 619 Elm st., Westfield (20)
Read, Hilton S., Prof. Arts Bldg., Atl. City (1)
Read, William T., 429 Cooper st., Camden (4)
Reading, H. E., 538 E. 29th st., Paterson (16)
Reason, John J., Roosevelt av., Carteret (12)
Rector, J. M., 681 Bergen av., Jersey City (9)
Reed, F., Grendon, Denville (14)
Reeves, E., 195 Lexington av., Passaic (16)
Reeves, J. Franklin, Bridgeton (6)
Reich, A. L., 83 Lyons av., Newark (7)
Reich, Henry, 31 Lincoln Park, Newark (7)
Reich, Jerome J., 1420 Maple av., Hillside (20)
Reich, S. B., Oradell (2)
Reid, Erwin W., Garfield (2)
Reilly, C. J., 321 S. 9th st., Newark (7)
Reilly, John V., 472 Sanford av., Newark (7)
Reingold, Alexander, 211 Garden st., Hoboken (9)

Reinhold, H. E., Teaneck (2)
Reisinger, P. B., 369 W. State st., Trenton (11)
Reissman, E., 31 Lincoln Park, Newark (7)
Reitter, G. S., 144 Harrison st., East Orange (7)
Remer, Daniel F., Mt. Holly (3)
Renner, Dan Smith, Skillman (18)
Renzuli, Francesco, 228 S. 7th st., Newark (7)
RePass,Paul E., 144 Harrison st., East Orange (7)
Rettig, I. L., 36 Milford av., Newark (7)
Reyner, D. C., 2703 Pacific av., Atlantic City (1)
Reynolds, Earl C., 657 Main av., Passaic (16)
Reynolds, G. G., 64 W. Main st., Freehold (13)
Reynolds, Harry C., 657 Main av., Passaic (16)
Rhoads, S. Creadick, Westville (8)
Rhone, David S., 1202 Haddon av., Camden (4)
Ribbans, Robert C., 63 Central av., Newark (7)
Rich, Charles, 191 Littleton av., Newark (7)
Rich, Harry H., 32 Broad st., Newark (7)
Richardson, Arthur, 60 Orange rd., Montclair (7)
Richardson, Charles A., Closter (2)
Richardson, Emma M., 577 Steven st., Camden (4)
Richie, E. W., Hackensack (2)
Ricketts, Henry E., 31 Lincoln Park, Newark (7)
Rieck, Allan, 507 S. Shore rd., Pleasantville (1)
Rieck, Walter R., 377 Kearny av., Kearny (9)
Rieman, Aloysius, 3566 Boulevard, Jersey City (9)
Riggins, Edwin N., 161 N. Arlington av., E. Or. (7)
Rink, Wm. E., Burlington (3)
Riordan, J., Rutherford (2)
Ristine, Edwin R., Westville (8)
Rizzolo, E. M., 250 Mt. Prospect av., Newark (7)
Robbin, Lewis, 18 Clinton pl., Newark (7)
Robbins, Charles M., 31 Lincoln Park, Newark (7)
Robbins, Eugene, 909 Broad st., Newark (7)
Robbins, Henry B., 144 Mercer st., Jer. City (9)
Robbins, Warren D., Cape May (5)
Roberts, A. H., 24 S. 9th st., Newark (7)
Roberts, D. C., 1536 N. Broad st., N. Orl'ns, La. (7)
Roberts, Edgar W., 760 Palisade av., W. N. Y. (9)
Roberts, Frank A., Budd Lake (7)
Roberts, Jos. E., Jr., 403 Cooper st., Camden (4)
Roberts, W. A., 9 Forest av., Caldwell (7)
Robertson, Grace M., 650 W. 7th st., Plainfield (20)
Robie, T. R., 144 Harrison st., East Orange (7)
Robinson, E. A., 149 Atkins av., Asbury Park (13)
Robinson, John T., Bound Brook (18)
Robinson, S. E., Waldwick (2)
Robinson, W. A., 62 Main av., Ocean Grove (13)
Rocco, Frank, 729 Summer av., Newark (7)
Rodman, E. Warren, Beverly (3)
Roeber, Wm. J., 21 Nesbit ter., Irvington (7)
Roemer, Jacob, 213 Broadway, Paterson (16)
Rogers, Alvin S., 126 N. Warren st., Trenton (11)
Rogers, Dorothy, Woodbury (8)
Rogers, Edw. B., 814 Haddon av., Collingsw'd (4)
Rogers, Harry, 144 Harrison st., East Orange (7)
Rogers, Harry L., Riverton (3)
Rogers, L. H., Municipal Colony, Trenton (11)
Rogers, Richard M., 1 Wallace st., Newark (7)
Rogers, Robert H., 49 9th av., Newark (7)
Rogers, W. N., 1255 Brunswick av., Trenton (11)
Roh, Robert F., 671 Broad st., Newark (7)
Rona, Maurice, 159 Bayard st., N. Brunswick (12)
Roop, W. O., 101 S. Indiana av., Atlantic City (1)
Rose, Abraham B., 212 S. Broad st., Elizabeth (20)
Rose, Mary D., 453 Park av., Orange (7)
Rosecrans, James H., 826 Hudson st., Hoboken (9)
Rosenberg, Albert B., 1921 Blvd., Jersey City (9)
Rosenberg, J., 692 Berger av., Jersey City (9)
Rosenberg, L. Charles, 11 Murray st., Newark (7)
Rosenberg, Louis, 2707 Pacific av., Atlantic City (1)
Rosenblatt, Sidney, 1904 Pacific av., Atl. City (1)
Rosenstein, Jacob L., 568 Bergen av., Jer. City (9)
Rosenstein, S. L., 557 Clinton av., Newark (7)
Rosenthal, A., 38 Mount st., Atl. Highlands (13)
Ross, Alex. S., 542 Cooper st., Camden (4)
Rossell, Edward W., 801 Cooper st., Camden (4)
Roth, Oswald H., 210 Littleton av., Newark (7)
Roth, R. F., 41 Haddon av., Westmount (4)
Roth, S. R., 31 Lincoln Park, Newark (7)
Rothenberg, Samuel, 132 Osborne ter., Newark (7)
Rothhouse, Burnet, 19 Lincoln Park, Newark (7)
Rothman, B. G., Sussex (19)
Rothschild, K., 49 Bayard st., N. Brunswick (12)
Rothseid, Abraham, 29 Scheerer av., Newark (7)
Rothstein, I. B., 16 Lyons av., Newark (7)
Rowan, Henry M., 224 W. State st., Trenton (11)
Rowe, J. A., Ridgefield (2)
Rowe, Norman L., 828 Grand st., Jersey City (9)
Rowland, James J., 321 Bay av., Highlands (13)
Rowland, John H., 159 New st., New Brunswick (12)
Roy, Bert W., Sussex (19)
Roy, Jos. N., 95 17th av., Paterson (16)
Rubin, A. David, 401 1st st., Asbury Park (13)
Rubinow, Saul M., 755 High st., Newark (7)
Ruch, Louis, Englewood (2)
Rucker, W. C., Hackensack (2)
*Rufe, John J., High Bridge (10)
Rullman, Walter, 58 W. Front st., Red Bank (13)
Rumage, Wm. T., 573 Sanford av., Newark (7)
Rundlett, Emelie V., 79 Prospect st., Jersey City (9)
Runnells, J. E., Scotch Plains (20)
Runyan, Wm. J., 106 Broad st., Bloomfield (7)
Runyon, L. P., 82 Somerset st., N. Brunswick (12)
Ruoff, Andrew C., 494 New York av., Union City (9)
Russell, Chas. B., 119 Hamilton av., Paterson (16)
Russell, David L., 690 Bergen av., Jersey City (9)
Russell, L. C., 192 Clinton av., Newark (7)
Russomano, R. L., 101 Clifton av., Newark (7)
Ruttenberg, Louis, Mantua (8)
Ruttenberg, Max, 303 Cooper st., Camden (4)
Ryan, John N., 158 Lexington av., Passaic (16)
Ryley, H. W., Rutherford (2)

ASSOCIATE MEMBERS

Randazzo, A. P., Garfield (2)
Reisman, David, 162 Spruce st., Philadelphia, Pa.(6)
Riccairdelli, Emanuel, 75 Linden av., Jer. City (9)
Riccollo, Anthony R., 833 Palisade av., Union C. (9)
Rineberg, I. E., 93 Bayard st., New Brunswick (12)
Robbins, Alex., 24 Johnson av., Newark (7)
Rosamilia, Robt. E., 480 N. 7th st., Newark (7)

ACTIVE MEMBERS

Sacco, Anthony G., 440 New York av., Union C. (9)
Sacco, Gregory E., 567 Colonial av., Westfield (20)
Sachs, Wilbert, 921 Bergen av., Jersey City (9)
Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
Salasin, Samuel L., 511 Pacific av., Atlantic C. (1)
Salvati, Leo H., 224 Walnut st., Westfield (20)
Samuels, S. L., 612 W. Front st., Plainfield (20)
Sandella, J. F., 169 New St., N. Brunswick (12)
Sandler, M., Fort Lee (2)
Sands, O. L., 90 W. Front st., Red Bank (13)
Sanfacon, Thomas A., 81 Park av., Paterson (16)
Santangelo, Stephen, 304 Varick st., Jersey City (9)
Santosky, Benj. B., 162 Bergen av., Jersey City (9)
Saradarian, A. V., 481 New York av., Union City (9)
Scarla, Michael, Hackensack (2)
Saslow, Benj., 680 Clinton av., Newark (7)
Satchwell, H. H., 640 Stuyvesant av., Irvington (7)
Saunders, O. W., 1700 Broadway, Camden (4)
Sax, Max T., 84 Grove st., Irvington (7)
Sayre, William D., 69 Maple av., Red Bank (13)
Sbarra, F., 531 W. Market st., Newark (7)
Scammell, Frank G., 40 S. Clinton av., Trenton (11)

Scanlan, D. Ward, 15 S. Illinois av., Atl. City (1)
Scasserra, B. B., 110 Nassau st., Princeton (11)
Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
Schaefer, Eugene P., 12 Harrison pl., Irvington (7)
Schaffer, Nathan, 172 S. Arlingt'n av., E. Orange(7)
Schall, R. E., 7th and Elm sts., Camden (4)
Schapiro, Joseph, 712 Palisade av., Union City (9)
Schectman, Vera, 385 Osborne ter., Newark (7)
Scheffler, W. A. H., 511 Cooper st., Camden (4)
Schellenger, E. A. Y., 429 Cooper st., Camden (4)
Schenk, Jos. R., 1177 Park av., Plainfield (20)
Schenker, B. N., 246 5th st., Jersey City (9)
Schept, Samuel S., 523 37th st., Union City (9)
Scher, Maurice A., 137 Lyons av., Newark (7)
Schildkraut, J. M., 170 W. State st., Trenton (11)
Schiller, Nicholas, 9 Pierce st., Newark (7)
Schilling, A. B., 727 Jafferson av., Elizabeth (20)
Schimmelpfennig, R. D., 258 Cl'rem't av., M'tcl'r(7)
Schisler, Milton M., Florence (3)
Schlein, August, 707 Park av., Hoboken (9)
Schlichter, C. H., 556 N. Broad st., Elizabeth (20)
Schmidt, Albert F., 81 Union av., Manasquan (13)
Schmidt, H. R., Lincoln Park (14)
Schmidt, Walter W., Cliffside Park (2)
Schmitz, Mathias, Denville (14)
Schmukler, Jacob, 29 Rutgers st., Maplewood (7)
Schneckendorf, S., 179 Harrison av., Jer. City (9)
Schneider, Charles A., 694 Clinton av., Newark (7)
Schneider, Louis, 874 S. 13th st., Newark (7)
Schneider, Louis A., 412 17th st., W. N. Y. (9)
Schrack, Helen F., 216 N. 5th st., Camden (4)
Schramm, Joseph A., 23 Darcy st., Newark (7)
Schreck, Harry, 139, Roseville av., Newark (7)
Schroeder, H. J. L., 134 W. State st., Trenton (11)
Schruggs, W. J., 3005 Kearsage rd., F'rv'w C'md'n 4
Schuchner, Wm. F., 550½ Jersey av., Jer. City (9)
Schuck, Traugott J., 58 9th st., Hoboken (9)
Schulman, B., Morristown (14)
Schulsinger, S., 48 Walnut st., Newark (7)
Schulte, H. A., 701 Clinton av., Newark (7)
Schults, Anna R., 207 Summer av., Newark (7)
Schultz, A. M., 379 Union av., Paterson (16)
Schurman, E. W., 710 Ocean av., Jersey City (9)
Schwartz, Henry C., Atco (4)
Schwartz, H. J., 5560 Hudson Blvd., N. Bergen (9)
Schwartz, Samuel H., 414 Park av., Plainfield (20)
Schwarz, B. T. D., 2787 Hudson Blvd., Jer. City (9)
Schwarz, Lewis, 2695 Boulevard, Jersey City (9)
*Schwarz, W. J. A., 269 Cator av., Jersey City (9)
Schwarzkopf, Geo., 2900 Pacific av., Atl. City (1)
Schweitzer, Roman G., 860 E. Jersey st., Eliz. (20)
Scielzo, N. F., 777 Madison av., Paterson (16)
Sciorsci, Edw. F., 609 Bloomfield st., Hoboken (9)
Scott, E. A., Belle Mead san, Belle Mead (13)
Scott, F., Franklin (19)
Scott, Fred W., 103 Bayard st., N. Brunswick (12)
Scott, Harold R., Morristown (14)
Scott, Michael, Skillman (18)
Scott, Parry M., Beverly (3)
Scott, R. Hunter, 205 Roseville av., Newark (7)
Scott, SamuelG., 141 Bergen av., Jersey City (9)
Scranton, C. W., 59 Washington st., E. Orange (7)
Scribner, Chas. H., Hamburg T'npike, P't'r's'n (16)
Scudder, F. D., 63 S. Fullerton av., Montclair (7)
Scullion, A., Cliffside (2)
Sealy, H. J., Dumont (2)
Seeley, Roy B., 78 N. Clinton av., Trenton (11)
Seidler, V. B., 16 Plymouth st., Montclair (7)
Seidler, William F., 29 Rossmore pl., Belleville (7)
Seidman, E. A., 580 High st., Newark (7)
Seidman, Marcus, 580 High st., Newark (7)
Seifert, Edwin A., 247 Claremont av., Montcl'r (7)
Seiler, B., Cliffside (2)
Seitzick, Hannah E., 733 Hamilton av., Trenton(11)
Sekerak, Albert J., 977 S. Broad st., Trenton (11)
Selinger, S., 413 16th st., West New York (9)
Sell, Frederick W., 113 Commerce st., Rahway (20)
Sellers, Robert R., 19 Chestnut st., Newark (7)
Sender, Fannie, 129 Main st., South River (12)
Senseman, Theodore, 3600 Pacific av., Atl. City (1)
Sesta, Jos., 242 Fulton av., Jersey City (9)
Sewall, Millard F., Bridgeton (6)
Sewell, Stephen, 212 Jersey av., Spring Lake (13)
Sexsmith, George H., 719 Ave. C, Bayonne (9)
Seybold, Arthur D., 302 E. 7th st., Plainfield (20)
Seymour, E. T., Tenafly (2)
Seymour, Geo., A., 253 Orchard st., Elizabeth (20)
Sferra, Alfred F. W., Bound Brook (18)
Shafer, Alfred H., 405 Cooper st., Camden (4)
Shafer, Frederick Wm., 634 Penn. av., Camden (4)
Shangle, Milt A., 34 Prince st., Elizabeth (20)
Shannon, James B., 56 Church st., Montclair (7)
Shannon, L. M., 66 Fullerton st., S., Montclair (7)
Shapiro, Chas. S., Maple Shade (3)
Shapiro, L. G., 375 Broadway, Paterson (16)
Shapiro, Louis, 146 Broad st., Newark (7)
Shapiro, Maurice, 750 Ave. C, Bayonne (9)
Shapiro, N. J., 192 Palisade av., Union City (9)
Sharp, Charles E., Port Norris (6)
Sharp, R. L., 719 Cooper st., Camden (4)
Shaul, F. G., 10 Washington st., Bloomfield (7)
Shaw, Ernest B., 811 Collings av., Collingswood (4)
Shaw, Jos. B., 119 S. Warren st., Trenton (11)
Sheaffer, C. P., 241 King's H'wy., E. Haddonf'd (4)
Sheehan, Daniel C., 773 Sanford av., Newark (7)
Sheeran, Vincent J., 269 Jewett av., Jersey City (9)
Sheets, C. C., Paulsboro (8)
Shemeley, Wm. C., Jr., 7 Haddon av., Camden (4)
Shenfeld, Isaac, 4806 Ventnor av., Ventnor (1)
Sheppard, Frank R., Millville (6)
Sheppard, R. L., 768 N. 27th st., Camden (4)
Sherk, A. Lincoln 2647 Westfield av., Camden (4)
Sherlock M. W., Vinel'd State School, Vineland (18)
Sherman, A. Russell, 671 Broad st., Newark (7)
Sherman, Elbert S., 671 Broad st., Newark (7)
Sherman, Fuller G., Woodbury (8)
Sherman, Samuel H., 81 Elmore av., Elizabeth (20)
Sherman, W. E., George & Schureman, N. B. (12)
Shill, Benjamin, 131 Renner av., Newark (7)
Shimer, A. Burton, 606 Pacific av., Atl. City (1)
Shimer, Floyd A., Phillipsburg (21)
*Shipman, Frank C., 3663 Boulevard, Jer City (9)
Shipman, Jas S., 542 Cooper st., Camden (4)
Shippee, David M., Midvale (16)
Shipps, Hammel, P., Delanco (3)
Shirrefs, Russell A., 55 Broad st., Elizabeth (20)
Shivers, C. H., deT., 121 S. Illinois av., Atl. City (1)
Shivers, Chas. H., 121 S. Illinois av., Atl. City (1)
Shook, B. E., 284 Bergen av., Jersey City (9)
Shope, E. P., 511 Cooper st., Camden (4)
Shore, Ernest L., 37 S. N. Jersey av., Atl. City (1)
Shull, E. C., 517 Cooper st., Camden (4)
Shull, J. V., 84 Market st., Perth Amboy (12)
Shullman, N. L., 538 45th st., Union City (9)
Sica, Samuel, 431 E. State st., Trenton (11)
Sickel, E. M., Lakewood (15)
Sieber, Isaac G., 204 Merchant st., Audubon (4)
Siegel, J. W., 96 S. 10th st., Newark (7)
Siegler, Julius, 646 Bergen av., Jersey City (9)
Sieveke, J., 106 Lexington av., Passaic (16)
Silk, Chas. I., 189 Rector st., Perth Amboy (12)
Sill, John B., 1129 Hamilton av., Trenton (11)
Silver, E. Drew, Hightstown (11)
Silver, George A., Hightstown (11)
Silvers, Homer I., 16 S. Suffolk av., Ventnor (1)
Silverstein, Benj. J., 32 Hillside av., Newark (7)
Silverstein, J. M., 73 Main st., Millburn (7)
Simeone, Peter A., 555 38st., Union City (9)

Simmons, Albert V., 720 Prospect st., Maplew'd (7)
Simms, Geo. F., 541 Page st., Lyndhurst (7)
Simon, Ludwig L., 201 Ferry st., Newark (7)
Simon, Morris L., 174 Washington pl., Passaic (16)
Simonson, Louis, 202 Osborne ter., Newark (7)
Simpkins, Raymond, Bridgeton (6)
Sinexon, Harry L., Paulsboro (8)
Singer, Max, 147 Johnson av., Newark (7)
Sinkinson, C. D., Jr., 1616 Pacific av., Atl. City (1)
Sinton, John Y., Imlaystown (11)
Sirken, Chas., 887 Summit av., Jersey City (9)
Sirott, Barnett H.,413State st., Perth Amboy (12)
Sista, Chas. R., 476 Hamilton av., Trenton (11)
Skinner, William F., Washington (21)
Skwirsky, Joseph, 170 Hawthorne av., Newark (7)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slaff, F., 16 Grove st., Passaic (16)
Slavin, Paul, Glen Gardner (10)
Sloan, Samuel L., 182 Belmont av., Paterson (16)
Slobodien, Benj. F., 107 Market st., P. Amboy (12)
Slocum, Harry B., Bath av., Long Branch (13)
Slupas, Aldona, 369 Belmont av., Newark (7)
Sly, John L., 382 Springfield av., Summit (20)
Smaine, E. C., Rutherford (2)
Small, E. Lester, Medford (3)
Smalley, Mahion C., Peapack (18)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, E. W., 167 N. Grove st., E. Orange (7)
Smith, A. L. M., 62 Bayard st., N. Brunswick (12)
Smith, Alex. L., 2672 Boulevard, Jersey City (9)
Smith, A. M., 344 Philadelphia st., Egg Harbor (1)
Smith, B. A., Ridgewood (2)
Smith, Byron J., 851 S. Orange av., East Orange (7)
Smith, E. L., Soho Hospital, Belleville (7)
Smith, E. W., 657 Main av., Passaic (16)
Smith, G. H., 136 Evergreen pl., E. Orange (7)
Smith, H. G., Cedar Grove (7)
Smith, Harold W., 179 Clinton av., Orange (7)
Smith, Houghton, 1063 S. Clinton av., Trenton (11)
Smith, J. J., 325 13th av., Newark (7)
Smith, J. Meredith, Hackettstown (21)
Smith, J. Vincent, 463 State st., Perth Amboy (12)
Smith, James D., 701 N. 6th st., Camden (4)
Smith, L. H., 32 Washington st., E. Orange (7)
Smith, Leon A., 72 Grove st., Passaic (16)
Smith, T. A., Short Hills (7)
Smith, W. Henley, 34 W. State st., Trenton (11)
Smith, Warren H., Newton (19)
Snavely, Earl H., City Hospital, Newark (7)
Snedecor, S. T., 50 Anderson st., Hackensack (2)
Snyder, J. E. C., 1023 Garden st., Hoboken (9)
Sobin, Julius, 24 Waverly Av., Newark (7)
Solomon, David, 723 Ave. C, Bayonne (9)
Somers, Fred L., 144 Harrison st., E. Orange (7)
Sommer, Geo., N. J., 120 W. State st., Trenton (11)
Sooy, L. T. Pitman (8)
Spalding, H. J., 512 45th st., Union City (9)
Spallone, Jos. C., 123 Mt. Prospect av., Newark (7)
Spano, Frank, 320 47th st., Union City (9)
Spath, George, 722 Hudson st., Hoboken (9)
Spence, Henry, 2540 Blvd., Jersey City (9)
Spencer, A., Dover (14)
Spencer, Ira T., Main st., Woodbridge (12)
Spencer, J. H., Jr., Newton (19)
Spickers, William, 6 Church st., Paterson (16)
Spiegelglass, A., Hackensack (2)
Spillane, T. H., Phillipsburg (21)
Spivack, David, 944 E. Jersey st., Elizabeth (20)
Spradley, J. B., State Hospital, Trenton (11)
Sprague, Edw. W., 86 Washington st., Newark (7)
Sprague, Seth B., 301 York st., Jersey City (9)
Spurgeon, D. L., Newton (19)
Staehle, Richard H., 34 Lyons av., Newark (7)
Stage, Earl DeW., Morristown (14)
Stahl, Alfred, 55 Lincoln Park, Newark (7)
Stahl, Charles, 659 Sanford av., Newark (7)
Stamps, G. R., 214 E. Verona av., Pleasantville (1)
Stanton, Nath. B., 734 Park av., Plainfield (20)
Staubb, E. Milton. 531 E. Broad st., Westfield (20)
Steadman, E. T., 107 Christopher st., Montclair (9)
Steel, William A., Beesley Point (5)
Steele, Stephen, 500 Wood av., Linden (20)
Steffen, Charles T., Dunellen av., Dunellen (12)
Stein, Emil, 607 Park av., Elizabeth (20)
Stein, George H., 411 Westminster av., Ellz. (20)
Stein, Harry M., 227 W. Broadway, Paterson (16)
Stein, Isadore, 210 Elizabeth av., Elizabeth (20)
Stein, Jacob M., 68 Columbia ter., Weehawken (9)
Stein, Joseph M., 956 Newton av., Camden (4)
Stein, L. A., 226 W. State st., Trenton (11)
Stein, Martin H., 163 Second st., Elizabeth (20)
Steinberg, Benj. Louis, Four Corners, Singac (16)
Steiner, Edwin, 19 Lincoln Park, Newark (7)
Stephenson, G. A., 145 Summit av., Summit (20)
Stern, Arthur, 224 E. Jersey st., Elizabeth (20)
Stern, Samuel, 2815 Pacific av., Atlantic City (1)
Steuart, David F. R., 10 De Barry pl., Summit (20)
Stevenson, A. M., 7506 Ventnor av., Margate (1)
Stevenson, Geo., W. Front st., Red Bank (13)
Stewart, Irving J., Swedeboro (8)
Stewart, Robert G., 79 Midland av., Montclair (7)
Stewart, Sloan G., 43 N. Carolina av., Atl. City (1)
Stewart, W. B., 8 N. Tallahassee av., Atl. City (1)
Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
Stillwell, Aaron L., Somerville, (18)
Stillwell, Harry C., 65 W. Milton av., Rahway (20)
Stimus, H. G., 300 Kaighn av., Camden (4)
Stinson, Richard, 641 E. 18th st., Paterson (16)
Stockfisch, Robt., 3644 Boulevard, Jersey City (9)
Stoddard, Gordon V., 41 S. Munn av., E. Orange (7)
Stokes, Earl B., 144 Harrison st., E. Orange (7)
Stokes, Joseph, Moorestown (3)
Stokes, Samuel Emlen, Moorestown (3)
Stolz, R. R., 23 Passaic av., Passaic (16)
Stone, A. L., 2838 Berkley st., Camden (4)
Stone, F. P., Tomlinson av., Laurel Springs (4)
Stone, R. G., State Hospital, Trenton (11)
Stout, Harry Wilson, Wenonah (8)
Stout, J. P., 165 Jewett st., Jersey City (9)
Strahan, F. G., 473 Broadway, Long Branch (13)
Strandberg, H. 94 Washington av., Carteret (12)
Straub, H. H., 242 Springdale av., E. Orange (7)
Straughn, C. C., 23 Monmouth st., Red Bank (13)
Strauss, Arthur, 130 Pavil av., Long Branch (13)
Street, D. B., 27 Woodlawn av., Jersey City (9)
Strelinger, Alexander, 689 Newark av., Eliz. (20)
Strom, A. 410 W. 7th st., Plainfield (20)
Stuart, A. A. D., Ridgefield Park (2)
Stuart, J. Earle, 552 E. Second st., Plainfield (20)
Stuart, William C., 518 Hudson st., Hoboken (9)
Subin, Harry, 1616 Pacific av., Atlantic City (1)
Sucoff, Moses C., 158 Hamilton av., Passaic (16)
Sullivan, C. J., 57 Paterson st., New Brunswick (12)
Sullivan, George F., 510 Hudson st. Hoboken (9)
Sullivan, James A., 668 Jersey av., Jersey City (9)
Sullivan, Wm. M., 43 Passaic av., Passaic (16)
Sulouff, S. Henry, 662 Newark av., Jersey City (9)
Summerill, Garnett, 330 Cooper st., Camden (4)
Summerill, John M., Pennsgrove (17)
Summers, A. D., 180 Nassau st., Princeton (11)
Summey, Thomas J., Moorestown (3)
Surnamer, Isaac, 345 Broadway, Paterson (16)
Suter ,Harry F., Pennsgrove (17)
Sutherland, W. W., 320 Broadway, Paterson (16)
Sutton, Jos., G., Es. County Hos., Cedar Grove (7)
Swan, Guy H., Beachwood (15)
Swayze, A. A., Hackensack (2)
Sweeney, W. J., 68 Clifton ter., Weehawken (9)
Swern, Nathan, 130 W. State st., Trenton (11)
*Swift, Edward M., Perth Amboy (12)

Swiney, Merrill A., 325 Ave. C, Bayonne (9)
Symes, Earl H., 161 Kearny av., Kearny, (7)
Synnott, Martin J., 63 Fullerton av., Montclair (7)
Szerlip, L., 31 Lincoln Park, Newark (7)

ASSOCIATE MEMBERS

Salway, Benjamin, 321 S. Broad st., Trenton (11)
Sandler, Samuel, 65 Tonnele av., Jersey City (9)
Seidelman, S. E., 1919 Greenwood av., Trenton (11)
Sherman, Arthur E., 25 Prospect st., E. Orange (7)
Siegel, Sidney L., 29 Bentley av., Jersey City (9)
Singer, Sina S., 1969 Boulevard, Jersey City (9)
Sisson, Nelson W., 144 Harrison st., E. Orange (7)
Snyder, Wm. J., 74 Columbia ter., Weehawken (9)
Sommer, G. N. J., Jr., 120 W. State st., Trenton (11)
Spickers, W., Paterson (2)
Statman, Arthur J., 337 Hawthorne av., New'k (7)
Stein, William, 71 Livingston av., N. Brunsw'k (12)
Stiles, Clarence C., 114 N. 19th st., E. Orange (7)
Storaci, Frank S., 749 Hamilton av., Trenton (11)
Swertfeger, H. W., 106 W. Broad st., Hopewell (11)
Szuch, N., 68 Main st., South River (12)

DENTAL ASSOCIATE MEMBER

Steigerwald, C. S., D.D.S., Jack. & Atl. av., A. C.(1)

ACTIVE MEMBERS

Taber, F. H., 3 Elm Row, New Brunswick (12)
Talbot, Herbert S., 144 Harrison st., E. Orange (7)
Talmage, Wm. G., Succasunna (14)
Tannert, Carl H., 331 31st st., Woodcliff (9)
Tarbell, Harold, 11 Pennington st., Newark (7)
Tataryan, H., 422 New York av., Union City (9)
Tatem, H., Pine st., Audubon (4)
Taylor, Herbert G., 590 Ridge av., Maplewood (7)
Taylor, H. W., Englewood (2)
Taylor, Walter A., 450 Rutherford av., Trenton (11)
Teeter, Charles E., 418 Orange st., Newark (7)
Teeter, John N., Englewood (2)
Teimer, Theodore, 17 Hillside av., Newark (7)
Tellman, D. H., 120 Lexington av., Passaic (16)
Temes, J. Howard, 293 Ege av., Jersey City (9)
Tempesto, Jos. A., 306 Hamilton av., Trenton (11)
Temple, Arthur H., 164 Jefferson st., Passaic (16)
Tenney, Albert S., 164 Harrison st., E. Orange (7)
Tennis, E. N., Tenafly (2)
Terhune, Percy H., 171 Paulison av., Passaic (16)
Terriberry, W. K. M. D. St. Oil Co. N. J., N. Y. C.(7)
Teskey, S., Bernardsville (14)
Tether, Russell K., Closter (2)
Thalheimer, E. J., Vineland (6)
Thomas, George N., Vineland (6)
Thomas, J. H., Jr., 270 Lenox av., So. Orange (7)
Thomas, Mary L., Vil. for Epileptics, Skillm'n (20)
Thomas, R. B., 793 Montgomery st., Jer. City (9)
Thomas, Ruth B., 1 Park pl., Bloomfield (7)
Thomas, T. S., Morristown (14)
Thomas, Wm. B. S., 1 Park pl., Bloomfield (7)
Thompson, A. F., 157 Harrison st., E. Orange (7)
Thompson, Austin B., 479 Highland av., Orange (7)
Thompson, C. S., Fair Oaks Sana., Summit (7)
Thompson, L. R., Morse av., Wyckoff (2)
Thompson, P. H., 4612 Westfield av., Camden (4)
Thomson, T. F., Lakewood (15)
Thorne, Nathan, Moorestown (3)
Thorne, Wm. P., 30 Main st., Butler (16)
*Thum, Ernest, 819 Ave. C, Bayonne (9)
Tidaback, J. D., 447 Springfield av., Summit (20)
Tidwell, G. W., Wallington (2)
Tidwell, H. F., 229 16th st., West New York (9)
*Tildon, John W., 54 N. Clinton st., E. Orange (7)
Timberlake, B. H., 1616 Pacific av., Atl. City (1)
Timlin, Jas. W., 64 Beech st., Arlington (9)
Tirrell, C. M., 725 High st., Newark (7)
*Titman, R. E., East Orange (7)
Toal, Joseph, Ridgefield (2)
Tobey, F. J., 11 Hazelwood av., Newark (7)
Todd, Francis H., 83 Auburn st., Paterson (16)
Tomassi, Chas. F., 173 Lafayette st., Newark (7)
Tomec, Richard F., 55 S. Park st., Montclair (7)
Tomkins, Wm., Hohokus (16)
Tomlin, H., Hurlburt, Wildwood (5)
Tomkins, G. B., Flemington (10)
Toren, Julius, State Hospital, Marlboro (13)
Towbin, Adolph, Lakewood (15)
Townsend, John B., Ocean City (5)
Toy, Calvert R., 22 Kirkpatrick st., N. Br'nsw'k (12)
Toye, John E., 590 Kearny av., Arlington (7)
Tracy, George T., Beverly (3)
*Trainor, James H., 40 Johnson av., Newark (7)
Traverso, Daniel, 705 D st., Belmar (13)
Treiber, Benj. A., 626 Perry st., Trenton (11)
Trippe, C. M., 702 Asbury av., Asbury Park (13)
Trossbach, H., Bogota (2)
Truax, Alfred J., Boonton (14)
Tuers, George E., 418 Park av., Paterson (16)
*Tunison, G. O., Oxford (21)
Turi, A., 57 Garside st., Newark (7)
Turner, C. F., Grove & Cambr. sts., Montclair (7)
Turner, Irvine F. P., 224 W. State st., Trenton (11)
Turner, Wm. F., 519 Magie st., Elizabeth (20)
Tushnet, Leonard, 668 18th av., Irvington (7)
Tutchulte, E., 111 Mt. Pleasant av., Newark (7)
Tweddel, George K., 239 Broadway, Paterson (16)
Twitchell, A. B., 162 S. Orange av., So. Orange (7)
Tymeson, Walter R., 310 Main st., Orange (7)
Tyndall, Alice E., 519 E. Broad st., Westfield (20)
Tyndall, H. H., 83 Highwood ter., Weehawken (9)
Tyndall, Martha W., 519 E. Broad st., W'tf'd (20)
Tyrrell, George W., 380 State st., P. Amboy (12)
Tynson, Francis B., Leonia (2)

ASSOCIATE MEMBERS

Taft, Herman L., 25 Liberty pl., Weehawken (9)
Tillis, Herman H., 11 Bergen st., Newark (7)
Tirico, J. G., 791 Bloomfield av., Montclair (7)
Trautwein, C. F., 19 Treacy av., Newark (7)

ACTIVE MEMBERS

Ulan, Oscar, 170 Fleming av., Newark (7)
Ulmer, Chester I., Gibbstown (8)
Ulmer, David H. B., Moorestown (3)
Underwood, J. Harris,Woodbury (8)
Upham, Helen T., 305 Third av., Asbury Park (13)
*Uptigrove, E. P., Vernon (19)
Urbaniak, H. S., 833 Brunswick av., Trenton (11)
Urbanski, Adrian X., 148 Market st., P. Amboy (12)
Urbanski, M. F., 314 Washington st., P. Amboy (12)
Urevitz, Abraham, 495 New York av., Union C. (9)
Uzzell, E. F., 2703 Pacific av., Atlantic City (1)

ASSOCIATE MEMBERS

Uhr, J. S., 131 Livingston av., N. Brunswick (12)

ACTIVE MEMBERS

Vaccaro, S. P., 511 Third av., Asbury Park (13)
Vaczi, Stephen, 983 S. Broad st., Trenton (11)
Vail, Herbert B., 301 Washington av., Belleville (7)
Vail, Jas. Lindley, 28 Holly st., Cranford (20)
Vail, Wm. Penn., Blairstown (21)
Vanderbeek, A. B., 174 Broadway, Paterson (16)
Vanderbeek, S. W., Englewood (2)
Vander Clock, C., 23 Passaic av., Passaic (16)
Vanderhoff, Irving M., 9 Clinton st., Newark (7)
Vandersluis, H. H., Park Ridge (2)

Van Der Veer, H. G., 295 Montgom'y st., Bl'mf'd (7)
Van Deusen, Edwin H., Vineland (6)
Van Duzer, Reeves B., 226 N. Park st., E. Or. (7)
Van Dyke, Benjamin S., Cranbury (12)
Van Dyke, Joseph S., Palisades Park (2)
Van Emburg, Geo. H., 575 Belgrove dr., Arl'gt'n (7)
Van Geison, E. J., 17 Park pl., Bloomfield (7)
*Van Geison, Wm. H., Bloomfield (7)
Van Horn, Alfred F., 514 Central av., Plainfield (20)
Vannatta, Geo. W., 224 N. Park st., E. Orange (7)
Van Ness, H. Roy, 444 Parker st., Newark (7)
*Van Neste, George V., Hopewell (11)
Vanneman, Joseph S., 180 Nassau st., Princeton (11)
Van Riper, A. Ward, 605 Main av., Passaic (16)
Van Sciver, John E. L., 106 Broadway, Camden (4)
Van Schott, G. J., Jr., 245 Lexington av., Pass'c (16)
Van Sickle, Albert W., Chester (14)
Van Urk, F. T., 210 Lexington av., Passaic (16)
Van Winkle, C. I., Rutherford (2)
Varney, W. H., Washington (21)
Varriano, John L., 3258 Boulevard, Jer. City (9)
Verbeck, George B., 26 Washburn pl., Caldw'l (7)
Villapiano, J. G., 706 Sixth av., Asbury Park (13)
Vinciguerra, M., 410 Westminster av., Elizab'h (20)
Visconti, Jos. A., 711 Garden st., Hoboken (9)
Vita, F. J., Grantwood (2)
Vitale, D. V., 681 Newark av., Elizabeth (20)
Viteri, Louis, Mt. Holly (3)
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth (20)
von Deesten, H. T., 268 Palisade av., Jersey City (9)
Von Hofe, Fred'k H., 255 Conway ct., E. Orange (7)
Voorhees, Florence E., 83 Lincoln Park, Newark (7)
Voorhees, Howard C., 43 Bayard st., N. Bruns. (12)
Voorhees, Lamar, Newton (19)
Voorhies, W. S., Mendham (14)
Vosburg, Fred, 125 Prospect st., Passaic (16)
Vostrosablin, N. A., 121 Grand st., Jersey City (9)
Vreeland, Hamilton, 232 S. Irving st., Ridgew'd (9)
Vreeland, R. D., 130 Woodland av., E. Orange (7)
Vreeland, R. J., 266 Van Houten st., Paterson (16)
Vreeland, William N., 32 Bergen av., Jer. City (9)
Vroom, W. L., Ridgewood (2)

ASSOCIATE MEMBERS

Valentine, E. J. J., 559 Summit av., Jersey City (9)

DENTAL ASSOCIATE MEMBER

von Deilen, A. W., 1910 Pacific av., Atlantic City (1)

ACTIVE MEMBERS

Wacker, William F., 42 Hollywood av., Hillside (20)
Wade, Simon F., 555 Newark av., Elizabeth (20)
Wagner, J. G., Riverside (3)
Wagner, Otto, 111 Stiles av., Elizabeth (20)
Wainwright, F. P., Bridgeton (6)
Wakeley, W. E. 521 Main st., East Orange (7)
Walker, Ada Harris, Vineland (6)
Walker, H. Burton, Vineland (6)
Walker, Harold G., Everett av., Wyckoff (16)
Walker, L. M., 110 N. S. Carolina av., Atl. City (1)
Walker, R. B., 108 Church st., New Brunsw'k (12)
Wallach, B., North Plainfield (18)
Wallhauser, H. J. F., 31 Lincoln Park, Newark (7)
Wallin, Alfred C., 195 Main st., Matawan (13)
Walsh, Ronald J., 118 E. 5th av., Roselle (20)
Walsh, T. M., Hasbrouck Heights (2)
Walsh, Thomas J., 335 S. Broad st., Elizabeth (20)
Walsh, Thomas J., 1158 E. State st., Trenton (11)
Walters, Geo., M., 648 E. Broad st., Westfield (20)
Walton, Gordon G., 17 Church st., Paterson (16)
Walton, R. W., 48 N. Fullerton av., Montclair (7)
Wambaganss, M., 44 Devine st., Newark (7)
Wandall, F. G., Clayton (8)
Wantoch, Joseph, 14 Carteret av., Carteret (12)
Warburton, Jack C., 277 Broadway, Paterson (16)
Ward, Albert J., 39 Elm st., Morristown (14)
Ward, Alfred W., Demarest (2)
Ward, G. Harold, Englewood (2)
Ward, Gertrude P., 41 Park pl., Bloomfield (7)
Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
Ward, Seth Allen, 325 Cooper st., Camden (4)
Ward, Wm. R., 112 Chancellor av., Newark (7)
Ware, Carl N., Shiloh (6)
Ware, Francis V., Millville (6)
Warner, Wm. H. A., 444 Central av., E. Orange (7)
Warncke, F. H., 523 Westfield av., Elizabeth (20)
Warren, Charles B., Bergenfield (2)
Warren, D. E., 265 Gregory av., Passaic (16)
Warren, Jacob, 372 E. 35th st., Paterson (16)
Warter, P. J., 626 W. State st., Trenton (11)
Washburn, Philip C., Greystone Park (14)
Wassing, Hans, 695 Broadway, Paterson (16)
Waters, Chas. H., 928 W. State st., Trenton (11)
Waters, Edward G., 39 Gifford av., Jersey City (9)
Watkins, Robert E., 517 5th av., Belmar (13)
Watman, A. J., 2761 Boulevard, Jersey City (9)
Watson, Fred S., 238 W. State st., Trenton (11)
Watov, S. E., 744 Beatty st., Trenton (11)
Watts, Wilbur, 436 E. State st., Trenton (11)
Way, Clarence W., Sea Isle City (5)
Way, Eugene, Sea Isle City (5)
Way, Julius, Cape May Court House (5)
Wayman, B. R., 1052 Stuyvesant av., Trenton (11)
Webb, Wilson D., Hackensack (2)
Weber, Francis C., 286 Mt. Prospect av., New'k (7)
Weber, J. Francis, 264Main st., So. Amboy (12)
Weber, Walter D., 305 23rd st., Union City (9)
Webner, C. Fred., 71 Lincoln Park, Newark (7)
Wechsler, Joseph, 3342 Boulevard, Jersey City (9)
Weems, Don B., Wenonah (8)
Wegryn, Louis S., 254 First av., Elizabeth (20)
Weigel, C. B., Salem (17)
Weigel, Edgar Wm., 970 Park av., Elizabeth (20)
Weigel, Elmer P., 727 Watchung av., Plainfield (20)
Weimann, M. L., 803 Station av., Haddon Hght.(4)
Weinberg, Maurice M., 377 Osborne ter., Newark (7)
Weiner, Samuel E., 904 Pacific av., Atl. City (1)
Weinman, Max H., 714 Scotland rd., Orange (7)
Weinstein, Morris, 643 Chancellor av., Irvingt'n(7)
Weinstock, Michael P., 13 Hillside av., New'k (7)
Weisler, Howard, 491 Centre st., Trenton (11)
Weiss, Abraham, 456 Palisade av., Wehawken (9)
Weiss, Louis, 849 S. 11th st., Newark (7)
Weiss, M. J., 734 Ave. C, Bayonne (9)
Weiss, Selma, 2 Stratford pl., Newark (7)
Weithaase, Helen E., Vineland (6)
Welcher, H. A., 5446 Hudson Blvd., N. Bergen (9)
Weller, Arthur, 19 Hillyer st., Orange (7)
Wells, Wm. C., Delanco (3)
Weres, James, Alpha (21)
Werner, G. H., Englewood (2)
Wescott, W. C., Del. & Pac. avs., Atlantic City (1)
West, Edgar L., 443 E. State st., Trenton (11)
West. G. E., Phillipsburg (21)
West, Gordon F., 527 Penn st., Camden (4)
West, H. R., Phillipsburg (21)
Westcott, H. F., 235 Gibbsboro rd., Clementon (4)
Western, Frederick B., 932 Salem rd, Townley (20)
Westney, Alfred W., 3005 Pacific av., Atl. City (1)
Wetterberg, Louis F., 389 School st., W'bridge(12)
Whaland, Berta, Bridgeton (6)
Wheatland, M. F., 727 Walnut st., Camden (4)
Wheeler, James A., 85 Van Reypen st., Jer. City(9)
Wheeler, W. K., 31 Lincoln Park, Newark (7)
Wherry, Elmer G., 323 Clinton av., Newark (7)
Whims, Clarence, 7117 Ventnor av., Ventnor (1)
White, Harry J., Bonnie B'n San. Scotch Plain(20)

White, Hugh M., 901 Summit av., Jersey City (9)
White, R. Rostin, 108 N. Trenton av., Atl. City (1)
White, Robert R., 25 S. Munn av., East Orange (7)
White, Thomas J., 50 Glenwood av., Jersey City (9)
Whiticar, John H., Ocean City (5)
Whitman, L. B., Bergenfield (2)
Whittacker, N., Hackensack (2)
Wiant, Herman E., 120 Windsor av., Haddonf'd(4)
Widetsky, Alfred, 69 Hamilton av., Paterson (16)
Wiener, Joseph, 601 Bangs av., Asbury Park (13)
Wikoff, J. L., 799 Pennington av., Trenton (11)
Wilbur, Franklin L., 504 Asb. av., Asbury Park (13)
Wilbur, Frederick P., Franklin (19)
*Wilbur, G. F., 502 Asbury av., Asbury Park (13)
Wilbur, William Lane, Hightstown (11)
Wilcox, Frank A., 415 16th st., W. New York (9)
Wild, Frederick A., Bound Brook (18)
Wilentz, Wm. C., 188 Market st., Perth Amboy (12)
Wilkes, Arthur C., 36 Osborne ter., Newark (7)
Wilkes, LeRoy A., 833 Berkeley av., Trenton (11)
Wilkinson, Boyd E., 266 Van H'ten st., Pat'son (16)
Wilkinson, Geo., 144 Old Bergen rd, Jer. City (9)
Willan, E. H., 238 Elmwynd dr., Orange (7)
Willard, Harry S., 266 Van Ho'ten st., Paterson (16)
Willey, F. Parker, 5 Park st., Bloomfield (7)
Williams, Frank A., 324 W. Jer. st., Elizabeth (20)
Williams, Geo. W., 217 N. Warren st., Trenton(11)
Williams, Harry D., 527 E. State st., Trenton (11)
Williams, Hiram, 230 Lexington av., Passaic (16)
Williams, J. J., 88 Walnut st., Newark (7)
Williams, L. D., 518 Park av., Plainfield (20)
Williams, Louis E., Madison (14)
Williams, R. A., Swathm're & Atl. avs., Ventnor (1)
Williams, W. C., Rutherfofrd (2)
Williamson, W. L., 22 W. 22nd st., Bayonne (9)
Willis, B. P., Rutherford (2)
Willis, John, 624 Pavonia av., Jersey City (9)
Willner, Irving, 18 Waverly av., Newark (7)
Willson, James H., 144 Harrison st., E. Orange (7)
Wilson, Charles W., Vineland (6)
Wilson, H. B., Hackensack (2)
Wilson, Herbert H., Bridgeton (6)
Wilson, I. E., 110 Chapel av., Merchantville (4)
Wilson, John G., 280 High st., Perth Amboy (12)
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Wing, Raymond, Blairstown (21)
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Winslow, John H., Vineland (6)
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Winter, G., Teaneck (2)
Winters, Walter M., 288 Broadway, Paterson (16)
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Wise, Lester D., 119 Morris av., Long Branch (13)
Wishnach, Meyer, 318 Broadway, Paterson (16)
Witkoff B., Woodbridge (2)
Witmer, J. D., Elm av., Metuchen (12)
Woelfle, Henry E., 69 Sherman pl., Jersey City (9)
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Wolfe, James C., 56 Church st.. Montclair (7)
Wolfe, William W., 383 Mulberry st., Newark (7)
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Wolgin, Philip L., 445 Elmora av., Elizabeth (20)
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Wood, Fiske, 115 Central av., Westfield (20)
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Woodruff, Dare, Vineland (6)
Woodruff, S. R., 16 Enos pl., Jersey City (9)
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Woolf, Bernard H., 15 Hedden ter., Newark (7)
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Wort, Frederick J., Jr., 1080 Broad st., New'k (7)
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Wright, Howard E., P. O. Box 276, Princeton (11)
Wroblewski, B., 1166 Thurman st., Camden (4)
Wry, Dean A., 244 Dayton av., Clifton (16)
Wry, Orlin V., E. Rutherford (2)
Wurts, Margaret M., Englewood (2)
Wyatt, Joseph H., 135 Clinton av., Newark (7)
Wyker, Arthur W., 1 Park pl., Bloomfield (7)

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York, J. L., New Milford (2)
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Young, I. H., 1203 Clinton av., Irvington (7)
Young. James L., Somerville (18)
Yuckman, Robert O., 224 W. Jer. st., Elizabeth (20)
Yuckman, William, 224 W. Jer. st., Elizabeth (20)
Yudkoff, Wm., 403 Boulevard, Bayonne (9)

ACTIVE MEMBERS

Zandt, Fred'k B., 2 Mercer st., Ham'ton Square(11)
Zeglio, Peter J., North Plainfield (18)
Zehnder, A. Charles, 188 Roseville av., Newark (7)
Zeitlin, H. H., 943 N. Wood st., Linden (20)
Zenneck, J. F., 17 Fourth st., Weehawken (9)
Zentsner, M. R., 1271 Hamilton av., Trenton (11)
Ziegler, Oscar, Wildwood (5)
Zimmerman, R., 1 Baldwin av., Newark (7)
Zimskind, Joshua N., 210 W. State st., Trenton(11)
Zingales, J. A., 101 Holly st., Elizabeth (20)
Zitani, Alfred M., 937 Wash'gton st., Hoboken (9)
Zuck, A. C., Washington (21)
Zweibel, Leonard, 29 Girard pl., Newark (7)
Zweigel, I., 92 Sunnyside ter., East Orange (7)

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THE 169th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

Held in Haddon Hall, Atlantic City, April 30, May 1, 2, 1935

THE OFFICIAL TRANSACTIONS

IN THREE PARTS

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PART 2. REPORTS OF THE SCIENTIFIC SESSIONS---Pages 68-71

PART 3. MINUTES OF THE WOMAN'S AUXILIARY---Pages 72-88

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THE ACADEMY OF MEDICINE
JUL 29 1935
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PART 1
MINUTES OF THE HOUSE OF DELEGATES

TUESDAY MORNING SESSION, APRIL 30, 1935

The opening session of the House of Delegates of the 169th Annual Meeting of The Medical Society of New Jersey convened at 10:10 o'clock on the morning of Tuesday, April 30, 1934, in Haddon Hall, Atlantic City, New Jersey, Dr. Lancelot Ely, of Somerville, the President of the Society, presiding, and Dr. J. B. Morrison, Newark, Secretary.

1. Invocation

The invocation was given by Rabbi Henry M. Fisher, Beth Israel Synagogue, Atlantic City, as follows:

Our God and Our Father, we thank Thee for the blessings of health and of strength that are ours, and for all other tokens of Thy goodness that we enjoy. We thank Thee for all of Thy children who are sharers with Thee in the development of civilization and in the progress of society. Especially do we give Thee our gratitude for those who have been engaged in the healing of bodily ill, and the prolongation of human society.

We think, too, in praise of Thee because of those men who have gained victory over many a disease that has played havoc with Thy children. For all those, O God, who have developed the science of medicine and added to the knowledge of therapeutics, we render Thee our gratitude, and for those, likewise, who have devoted themselves to research in the laboratory and to the practice of their calling in the hospital and the home.

For the manner in which these men have lived, true to the hippocratic oath of old, for their idealism and devotion to their profession, we give Thee our gratitude and as we thank Thee, O God, for the benefits that we know, so do we turn to Thee in supplication.

Be with all Thy children who labor unselfishly for the well-being of society, be with every group that is banded together for the healing of men, be with this Society, its officers and its members; grant that the spirit of wisdom and knowledge and understanding may abide in these sessions. May all who are here gain inspiration in communion, one with another, and in the themes and the theses that are propounded.

Help us in our needs, guide us all in our difficulties. Grant that every day that Thou mayest vouchsafe unto us we may carry on in faith, in hope, in courage, and with cheer.

We ask it in Thy name, our God, and our Father, our Helper, and our Healer. Amen.

2. Address of Welcome

PRESIDENT ELY: We will have the address of welcome by Dr. C. Coulter Charlton, the President of the Atlantic County Medical Society.

DR. CHARLTON: Mr. President and Members of the Medical Society of New Jersey: As President of the Atlantic County Medical Society, I wish to extend a cordial welcome of our city to you at your One Hundred and Sixty-ninth Annual Meeting. Judging from the scientific program, I feel sure we are going to have a very interesting and profitable meeting. I trust your social program will be equally successful, and when you decide on your meeting for next year, we hope you will come back to Atlantic City. Thank you. (Applause.)

3. Minutes of 168th Annual Meeting

PRESIDENT ELY: We will listen to the reading of the minutes of the One Hundred and Sixty-eighth Annual Convention.

DR. J. BENNETT MORRISON: Inasmuch as the minutes of the One Hundred and Sixty-eighth Annual Convention have been published and are in your hands, I move they be received.

The motion was seconded, put to a vote, and carried.

4. Memorial to Ex-President Costill

PRESIDENT ELY: News came to our Board of Trustees last evening of the death of one of our Ex-Presidents. It seems rather sad that we receive news of this kind just at the opening of our Convention. Only two or three years ago we had the sad experience of hearing about the death of one of our Ex-Presidents, and again we have the sorrow of hearing of the death of Dr. Henry B. Costill, who was President during the year of 1921.

The Board of Trustees last evening appointed a committee to report and pass suitable words of condolence on the death of Dr. Costill. I will ask Dr. McBride to read the report.

DR. ANDREW F. MCBRIDE: Mr. President and Members of the Society: We were indeed saddened last night at our meeting, having learned of Dr. Costill's death. Dr. Eagleton,

Chairman of the Board of Trustees, appointed a committee to draft a resolution covering it.

We are offering the following memorial for your adoption:

The death of Dr. Henry B. Costill, a Past President of this Society, has just been announced, and it is most appropriate that this Society be at this time reminded of the great service that he rendered.

In 1922 the medical profession had so little political influence that a law was passed licensing chiropractors and creating a separate board for them, the legislators even refusing to give them a hearing. As a result of this treatment, the Society got busy and organized the first Welfare Committee, which in one year secured the repeal of this act, and the passage of the limited practice act which is now in force. In its passage through the Legislature, Dr. Costill showed rare political acumen and outstanding ability in dealing with men. Those of us who were members of the Welfare Committee at that time realize, and we want the Society to know, that he was the guiding spirit of the technic in the passage of the law through the Legislature, as he was in all other questions that had any bearing on public health.

The motion was seconded.

PRESIDENT ELY: This resolution will be referred to the Committee on Resolutions and Memorials. Dr. B. S. Pollak is chairman of that committee.

Action, Sect. 43.

5. REFERENCE COMMITTEES

(Jour., April, page 230.)

The appointment of committees will be next in order.

Credentials:

Spencer T. Snedecor, Chairman
J. Bennett Morrison
E. J. Marsh

Resolutions and Memorials:

B. S. Pollak, Chairman
Frederic J. Quigley
A. D. Hutchinson
E. H. Snavely
W. B. Morris

Miscellaneous:

J. F. Condon, Chairman
Hugo Alexander
W. C. Wilentz
R. B. Seeley
Dan S. Renner

Last year we adopted the plan of Reference Committees and I will name the different Reference Committees and their duties.

Reference Committee "A"—To consider the Report of the President and the Address of the President and the President-Elect, Report of the Executive Secretary, Report of the Board of Trustees, and Report of the Secretary.

This committee is made up of the following members:

Edward W. Sprague, Chairman
Millard F. Sewall
I. F. Frost
E. G. Herbener
G. M. Knowles

Reference Committee "B" will consider the Reports of the Publication Committee, the Physicians' Lien Law Committee, Finance and Budget Committee, Report of the Treasurer, Report of the Insurance Committee, and Report of the Committee on Constitution and By-Laws. The committee is as follows:

Chester I. Ulmer, Chairman
Thomas B. Lee
F. W. Pinneo
Frederick P. Wilbur
A. H. Coleman

On account of illness, Dr. Pinneo is replacing Dr. Joseph W. Hurff on this committee.

Reference Committee "C" will consider the Reports of the Committee on Program and Arrangements, Committee on Scientific Work, Committee on Scientific Exhibits, Committee on Arts and Hobby, and Delegates to the American Medical Association.

Reference Committee "C" is as follows:

Edgar A. Ill, Chairman
George T. Tracy
George F. Dandois
John E. Maher
B. G. Sherman

Reference Committee "D" will consider the Reports of the Committee on Public Health Committee on Hospitals and Medical Education, Medical Adisory Committee to the State E. R. A., Committee on Maternal Welfare, and the Board of Medical Examiners.

Reference Committee "D" is as follows:

A. A. Lawton, Chairman
David W. Scanlan
H. D. Bellis
C. H. Schlichter

Word was received this morning from the other member of this committee, Dr. Louis A. Pyle, on account of business conditions he cannot be present at the Convention, so I am placing in his place Dr. Charles B. Kelly.

Reference Committee "E" is to consider the

Report of the Welfare Committee and its subcommittees on Legislation, Medical Practice Uniform Medical Practice Act, Workmen's Compensation.

Reference Committee "E" is as follows:

William H. Areson, Chairman
Leslie Myatt
Arcangelo Liva
David B. Allman
E. Watkins

Reference Committee "F" is to consider the Reports of The Advisory Committee to the Woman's Auxiliary, Committee on Cancer, Committee on Nursing and Nursing Education, Committee on Honorary Membership and Committee on Medical Defense.

Reference Committee "F" is as follows:

William F. Costello, Chairman
L. H. Bloom
Nathan Swern
B. T. D. Schwartz
D. W. Green

We will call on the different committees to report. The first committee will be that on Program and Arrangements, Dr. William J. Carrington.

6. Program and Arrangements

DR. MORRISON: Reporting for Dr. Carrington, the program as submitted has been published and is complete and in your hands. (Jour., April, p. 237.)

7. Scientific Work

PRESIDENT ELY: The second report will be that of the Committee on Scientific Program—Dr. Ralph K. Hollinshed. (Jour., April, p. 238.)

DR. HOLLINSHED: In so far as we know, the only change in the scientific program up to this time will be that of substitution for Dr. David D. Berlin, of Boston, who was taken sick a short time ago with undulant fever, and will be unable to be present. He is sending one of his associates, Dr. Reeseman, who is well acquainted with the work done in this clinic, and I am sure the program will be carried on just as well as if Dr. Berlin were here.

PRESIDENT ELY: The reports of the Committee on Program and Arrangements, and the Committee on Scientific Work will be referred to Reference Committee "C"—Dr. Ill, Chairman.

Action, Sect. 47.

8. President's Report

I note the next order of business will be the Report of the President, and as the main report is printed in the April Journal, page 187, I will just make a short supplementary report of the activities that have taken place since March 25th.

President Ely read his supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE PRESIDENT

Supplementary activities of your President since his report was rendered centered around the Annual Meeting, and the legislative bills being supported and opposed.

Legislation. Careful follow-up by the Executive Secretary on bills and reports to County Society officers and key men have been made. There is need for more extensive interest and effort in demonstrating interest by medical men in pending bills. It is not sufficient to protest to our officers and Executive Secretary. Our protests must be formally and promptly made to our legislative representatives in their home counties.

I recommend that the legislative representatives be contacted and invited to a medical social meeting and urged to express their views and attitude on medical, health, and cult legislation. I believe that the legislators should be gradually prepared in each county to understand the purpose and provisions in the Uniform Medical Practice Act when it is introduced next year. Now is a good time to insure proper consideration and support of this bill.

Speakers' Bureau. I would further recommend the extension of the work of the Speakers' Bureau, and the use of the radio by New Jersey physicians who are members of our Society.

Inter-State Contacts. I recommend more frequent and intimate contact with nearby organizations of our professional colleagues, especially in New York and Pennsylvania.

Consultations. I would recommend that some form of "coördinating committee" integrate the work of certain committees whose work overlaps necessarily—viz., Public Health, Medical Practice, Legislation, etc.

Closely related to this recommendation is one that the State President and the County Presidents meet in council monthly or bi-monthly or at the call of the President to interpret and coördinate the plans of the State and County Societies.

Demonstration of Business Office in a County Society. The State Medical Society organization for *service* is well advanced. I would strongly recommend and urge that at least one medium-sized County Medical Society be organized as a medical service agency, with proper office equipment and clerical aid, and to serve as a practical demonstration that the medical profession can and will furnish organized medical service to individuals and to institutions and agencies in the community at fair charges. The members of organized medicine can thereby prove not only their ability but their willingness to meet "public demands" for medical care when such demands are evidenced by increased calls received for medical service, by the best prepared and equipped professional group in

the community from persons in need of such care, and not alone by promotion of intermediary services, or malingerers seeking free service.

This report was referred to Reference Committee "A". Report of Committee, Sect. 44.

PRESIDENT ELY: I was hoping at this time we would have our President-Elect present, to speak on some of the problems of legislation that have faced us this year. No doubt, we will hear from Dr. Newcomb later.

Sects. 18 and 36.

We will next hear the Report of our Executive Secretary, Dr. Wilkes. Dr. Wilkes informed me just a little while ago that he had no supplementary report to make.

See Sect. 16.

9. TRUSTEES' REPORT

The next order of business will be the Report of the Chairman of the Board of Trustees, Dr. Eagleton.

DR. WELLS P. EAGLETON: Mr. President, I only want to read a part of the report that has been published: (Journal, April, p. 197.)

"In the opinion of the Chairman of the Board of Trustees, the outstanding principle of Dr. Ely's presidency has been his constant attempt to have all actions of the different officers of the Society coördinated and approved by all members of the different committees, with a view that a larger and ever-increasing number of members from all parts of the state not only will be brought into the active working of the Society, but feel that they are important and of assistance to it.

"With this view, Dr. Ely has personally consulted the Chairman of the Board of Trustees as well as various members of the Board and chairmen of the different committees before deciding on any action whatsoever, and then had their suggested action endorsed by the Board of Trustees. This is a continuing and a most encouraging enlargement of the policy first enforced last year by the personal energy and self-sacrifice of Dr. Ely, of having a large number of committees, each of which had definite duties to perform and was expected to call frequent meetings of all its members.

"This coöperation will, I am sure, be of lasting benefit to the Society, for while it has entailed much additional labor on the part of the President, Dr. Ely, it has made a large number of men coördinate, and by interesting them has made them accept responsibilities which they otherwise would have avoided or even completely neglected.

"The Board of Trustees itself has now become what it must be as an efficient organization for the safeguarding and furtherance of the interests of the medical profession, namely, a cabinet of the President, to advise and assist him, but never to conspire or render aid to efforts to undermine his authority or his actions.

"The House of Delegates at the last Annual Meeting, by an overwhelming voice, voted condemnation of all efforts of hindrance to the action of its duly elected President by others to further the special interests of any group or individual not in sympathy with an aggressive policy by the Society.

"At the completion of his term, Dr. Ely can feel happy, and we do hereby congratulate him, in the knowledge that today, for the first time in years, every officer as well as every employee and all committees feel their responsibilities for concerted action under the leadership of the duly elected President, as was first propounded in the formulation of the principles adopted in 1932 to make the Society with all its activities center in the President during the year of his presidency.

"At the expiration of his second term as Chairman of the Board of Trustees, it is a source of personal gratification to him that under the régimé of the last two Presidents, he has been privileged to be of some assistance to them in bringing back the leadership of The Medical Society of New Jersey for the protection of the licensed physicians of New Jersey, which in his opinion, must continue to be the main object of the Society's existence." (Applause.)

Action, Sect. 44.

10. TRUSTEES' SUPPLEMENTARY REPORT

PRESIDENT ELY: At this time we may hear a Report from the Secretary of the Board of Trustees. Dr. Nafey, you have a short report to make.

DR. H. W. NAFEY: Two meetings of the Board of Trustees have been held since the report of the chairman was completed and printed in the Journal. A supplementary report, therefore, is necessary.

11. PURE FOOD AND DRUGS ACT

DR. NAFEY: At the last meeting of the House of Delegates, the question of the administration of the Pure Food and Drugs Act was discussed. Since that time the Welfare Committee has studied this matter, subsequent to a hearing with Mr. Armbruster. The Board of Trustees has received a report of the Welfare Committee and has adopted the following resolution:

"*Resolved,* That the Board of Trustees recommends to the House of Delegates as a result of the Welfare Committee's investigation, headed by the President, Dr. Ely, that the attention of the Senators and Congressmen of New Jersey be called to this matter, and that the New Jersey Medical Society request an investigation of the present enforcement of the Pure Food and Drugs Act."

PRESIDENT ELY: I believe Dr. Burritt has a resolution that he would like to offer in regard to action taken in his County, Union County. Dr. Burritt!

Dr. Burritt presented the resolution.

Whereas the attention of the members of The New Jersey State Medical Society has already been called to the lack of proper enforcement of the present Pure Food and Drug Law under its present administrator, and

Whereas the physicians, being compelled to depend upon the uniformity of drugs in all their missions of mercy, are vitally interested in the purity and uniformity of the drugs prescribed, and

Whereas the physicians of New Jersey, believing that legislation to control advertising should not be confused with the legislation to control the purity and uniformity of drugs and foods, and

Whereas it has been demonstrated that the Federal Trade Commission already has power to prevent all false advertising of foods, drugs or any other product, if they are persuaded to do so, and

Whereas the series of offenses that have on occasion been successfully punished under the present mandatory Wiley Act demonstrates that it is sufficiently powerful for enforcement if properly administered, and

Whereas some of the interested parties have already been accused of and have admitted allowing certain food and drug producers to repeatedly violate the law without punishment, while other producers for even lesser offenses are criminally prosecuted for a first offense, and

Whereas the same individuals charged with the administration of the law who have allowed repeated violations of the law, which is a mandatory law and provides only criminal prosecution for every offender, have now sought to have a new law which will legally give them discretionary power in its enforcement, and

Whereas this new bill, Senate Bill No. 5, the Copeland Bill, is by its own words made an uninforceable law, sponsored by one who sets himself up against false advertisement of drugs and patent medicines while he is himself at the same time lending his voice to the radio programs advertising patented medicines, and

Whereas the Committee on Foods and the Council on Pharmacy and Chemistry, and the Investigations Bureau of the American Medical Association have exercised selections unwarrantably in the notices of judgement that they have published, and have permitted the license to use their seal on the advertisements of products that are even at the same time being successfully prosecuted by libel actions under the Food and Drug Law, and

Whereas it is our duty as physicians to assume leadership in promoting free and open discussion of a condition concerning which we should have expert knowledge if we had honest information;

Therefore, be it resolved, That the New Jersey State Medical Society does hereby urge, and as representatives of the ethical physicians of the United States, do hereby demand a complete Congressional investigation of the enforcement of the present Pure Food and Drug Law, the investigating committee to have full power to call individuals and records under oath, before any new pure food and drug legislation shall be enacted by the Congress, and

Be it further resolved, That the New Jersey State Medical Society require its Secretary to transmit copies of this resolution to the Congressmen and Senators from New Jersey, the Secretaries of Agriculture, Commerce and the Treasury, the Secretary of the American Medical Association, and the secretaries of all the state medical societies of the United States, and to present copies of this resolution to the editors of all the daily newspapers of New York City, Philadelphia, Atlantic City and other cities in New Jersey.

Dr. Ill: May I second this, with the knowledge that I have had experience in this matter at Washington some years ago. I do not think a more fair Bill has ever been suggested to the Senate than this Bill of Copeland's.

I would like to second this resolution.

President Ely: Is there any further discussion? If not, this resolution will be referred to the Committee known as that on Resolutions and Memorials, of which Dr. Pollak is Chairman.

Action, Sect. 43.

12. Kipp Memorial Fund

Transactions, 1934, p. 51

Dr. Nafey: Dr. Marsh, the Treasurer, has been requested to act as custodian for the C. J. Kipp fund of the Section of Ophthalmology and Otolaryngology established last year. Authorization to assume responsibility for this fund by the Treasurer is referred to this meeting of the House of Delegates for action.

I move these resolutions be referred to the proper Reference Committee.

The motion was seconded.

President Ely: It has been moved and seconded that these resolutions be referred to the Committee on Resolutions and Memorials, the Chairman of which is Dr. Pollak.

Action, Sect. 43.

Dr. Ely: I think, Mr. Secretary, a resolution you have is in order.

Dr. Morrison presented the following resolution on the Kipp Memorial Fund, which has been proposed by the Section on the Eye, Ear Nose and Throat on June 7, 1934:

Resolved, that the Eye, Ear, and Throat Section proceed to establish a fund to be known as the Charles J. Kipp Memorial Fund, and to be used under the direction of the Section for the encouragement and assistance of original scientific or

public health work in ophthalmology or otology in New Jersey.

Resolved, that the House of Delegates be requested to approve this action.

Resolved, that all moneys belonging to the Fund be placed in the custody of the Treasurer of the Society (the Board of Trustees consenting), to be held by him as a separate fund, and to be paid out only on authorization of the Section, as attested by the signatures of its Chairman or Vice-Chairman and its Secretary.

Adopted by the Section June 7, 1934. (Transactions, 1934, p. 51.)

DR. F. J. QUIGLEY: I move that this resolution take the same course as the previous resolution.

The motion was seconded.

PRESIDENT ELY: It has been moved and seconded that this resolution take the usual course and be referred to the Committee on Resolutions—Dr. Pollak, Chairman.

The motion was put to a vote and was carried.

Action, Sect. 43.

13. SECRETARY

The next order of business is a report from the Secretary, Dr. Morrison.

Report, Jour., April, p. 196.

SUPPLEMENTARY REPORT OF THE SECRETARY

To the President and Members of
the House of Delegates:

Since my report which was published with the Annual Reports we have added to the list of Active Membership ..... 48 more names
And to the list of Associate Members 1
With the previous report of 3055

Makes a total of 3104
An increase over last year of .... 238 members.

This is by far the largest increase in membership in any one year since I assumed the duties of your Secretary twelve years ago.

Respectfully submitted,
J. B. Morrison, M.D.,
Secretary.

DR. MORRISON: Mr. President, this is just a short supplementary report. Since my report was published with the annual reports, we have added to the list of active members forty-eight names and one associated. With the previous report of 3055, this makes a grand total of 3104 members, an increase last year of 238 members. This is by far the largest increase in membership in any one year since I assumed the duties of Secretary twelve years ago.

PRESIDENT ELY: These different reports just given will be referred to Reference Committee "A", of which Dr. Edward W. Sprague is Chairman.

Action, Sect. 44.

14. PUBLICATION COMMITTEE

Report, Jour., April, p. 200

The Report of the Publication Committee—Dr. Barkhorn.

Dr. Henry C. Barkhorn presented the prepared supplementary report, as follows:

PUBLICATION COMMITTEE REPORT

The Publication Committee has had its most successful year. There were regular monthly meetings with several special meetings. These meetings were all well attended. Because of their enthusiasm, Dr. Ely and Dr. Eagleton were helpful in enabling us to publish an up-to-the-minute outline of all activities.

Our contacts with the Woman's Auxiliary and the County Secretaries and Reporters are more cooperative than ever before, in addition we have given a great deal of publicity to local medical societies throughout the state.

We have continued our effort to place articles by New Jersey doctors in a prominent position in the Journal, and are contemplating a department in which articles by New Jersey doctors published elsewhere, will be abstracted.

A change in the arrangemnet of the Journal was made a year ago. Additional improvements made during this year consist of changed headings of pages in order to make our Journal uniform with other outstanding publications, and as a help to readers and librarians. We also improved the Seal of the Society and published more long abstracts of articles received from County Society meetings.

Because of the splendid and thoughtful work of our Editor, Dr. Overton, and the many helpful suggestions of our Executive Secretary, Dr. Wilkes, the editorials have been especially constructive and thought provoking. If you reread those of the year just passed, you will be amazed at the number of pertinent topics discussed. We hope the new boxes for filing will be used extensively for we thoroughly believe our Journal is the most helpful of all State Journals and that it should be carefully preserved for future reference.

Our financial condition is excellent. The economies inaugurated in the recent past have been continued. We think we are giving the members the best possible Journal at the lowes possible cost and would respectfully suggest the same amount as last year, $12,500.00 for our budget.

Finances. The following is a summary of our finances to date. A complete financial report for the fiscal year will appear in the Transactions. (See p. 8.)

JUNE 1, 1934—APRIL 29, 1935

RECEIPTS

Receipts sent to Dr. Marsh	$6170.38
On hand in bank	666.09
	$6836.47

Expenses

Printing and Mailing Journal	$10,201.34
Reprints	114.75
Addressograph	33.29
Code Authority	10.00
Editorial office expenses, attributed to Journal	353.15
	$10,712.53

Comparative Statement

	1933-34	1934-35
Receipts—June 1-April 29	$ 6,392.11	$ 6,836.47
Expenses—June 1-April 29	10,392.11	10,712.53

Respectfully submitted,

Henry C. Barkhorn, M.D., Chairman,
Publication Committee.

President Ely: This report will be referred to Committee "B"—Dr. Ulmer, Chairman.

Action, Sect. 45.

June 30, 1935.

The financial report of the Publication Committee for the year ending June 30, 1935, submitted on June 30, is as follows:

PUBLICATION COMMITTEE REPORT
1934-1935

Receipts

Advertising	$7,699.76
Coöperative rebate	189.36
Journal copies	8.58
Extra subscriptions	43.15
Associate Members, subscriptions	510.75
Bills receivable	1,142.25
	$9,593.85

Expenses

Commissions	$ 1,668.54
Discounts	266.00
Tax on checks	.52
Printing and mailing of Journal	11,454.80
Reprints	135.50
Addressograph	33.29
Code Authority	10.00
Editorial Office expense, attributed to Journal	473.78
Editor's traveling expense, attributed to Journal	173.44
	$14,215.87

Comparative Statement

	1933-34	1934-35
Advertising	$ 8,294.81	$ 8,804.74
Extra subscriptions	42.50	43.15
Sale of Journal	10.86	8.58
Printing and mailing of Journal	11,109.19	11,454.80
Reprints	198.75	135.50
Commissions	1,120.56	1,668.54
Discounts	161.92	266.00

Summary

Amount of advertising secured by Coöperative	$3,884.35
Amount of advertising secured locally	4,920.39
Discount and commission allowed Coöperative	951.82
Discounts allowed local advertisers	59.00
Commission paid local agents	923.72
Total amount of advertising	8,804.74
Total cash receipts, all sources	8,451.60
Amount sent Treasurer (including July advance—$58.25)	7,423.68

Distribution of Receipts

Dr. Elias J. Marsh, Treasurer	$7,423.68
Commission, local agents	923.72
Retained in bank in accordance with clearing house ruling	100.00
Adjustment on advertisement	3.68
Tax on checks	.52
	$8,451.60

Net Expenses

Printing and mailing of Journal	$11,454.80
Reprints	135.50
Addressograph	33.29
Code Authority	10.00
Editorial Office expense, attributed to Journal	473.78
Editor's traveling expense, attributed to Journal	173.44
	$12,280.81

15. Treasurer's Report

We will now ask for a report from Dr. Marsh, the Treasurer.

Dr. Elias J. Marsh (Paterson): Mr. President, copies of certain figures are now being distributed to the house (see table, p. 9). I want to say a preliminary word. It is impossible to make the customary Treasurer's Report at this time because the fiscal year is not complete until the 31st of May. The report, as soon as completed, will be published in the Journal and will be presented to the Auditing Committee (p. 10). In the meantime, I have made perhaps a more interesting study than the ordinary report. I made an analysis of certain figures that, I think, will be more interesting to the delegates than the report which we generally have. I have made a comparative study of total figures for the past three years, taking the calendar year as the basis of the study, because in that way I can get the most recent figures.

REPORT OF THE TREASURER

1935

OPERATION OF THE ASSESSMENT

Comparative Tables

Calendar Year	Assessment	Receipts from Assessment	Expenses Chargeable to Assessment	Operating Net Balance	Net Cost per Member
1932	$13.00	$37,351	$34,116.28	$3234.72	$12.00
1933	10.00	29,644	34,722.32	—5078.22	11.80
1934	13.00	38,574	32,185.86	5388.14	10.85
Average	12.00	35,190	33,674.82	1515.22	11.55

This study is made on the basis of the calendar year because the fiscal year will not end till June 1st, and in a succession of years it makes little difference at what point of the cycle the entrance is made, though for any single year the difference between calendar and fiscal years might be appreciable. In this way the latest available figures can be used. The assessment is made for the calendar year.

The change from the old to the present administrative organization occurred about the middle of the period shown.

ANALYSIS OF THE ASSESSMENT

(Showing each member where his $13.00 goes)

Journal, editing and publishing, but excluding share in general office expenses, net	$3.75
Executive officer, salary and expenses	2.03
Office, rent, services and expenses	1.43
Office equipment and furnishing	0.50
Secretary, salary and expenses	0.97
President's office, expenses	0.05
Treasurer's office, expenses	0.02
Welfare Committee	0.30
Public Health Committee	0.05
Arrangements Committee	0.10
Other committees, expenses	0.06
Printing, postage and stationery	0.69
Annual Meeting, 1934	0.51
Legal services	0.13
X-ray boxes	0.04
A. M. A. Delegates, railroad fares	0.03
Miscellaneous	0.19
Balance	2.15
	$13.00

A similar analysis was presented some years ago, the assessment then being $15.00. It may be found in the Transactions for 1930, page 20. The part of the costs covered by the receipts of the Publication Committee and other miscellaneous income have been deducted before this calculation was made.

You see that the assessment was $13, $10 and $13, and the average was $12 for the period of three years, the receipts and expenses chargeable to the assessments. By that I mean the expenses, after those paid for by the Journal receipts and certain other miscellaneous items have been deducted, the expenses which were paid purely by the assessment.

The operating net balance in 1932 for the year—we had an operating net balance of something over $3200. The next year the assessment, you remember, was reduced to $10 and as a result we went over $5000 "in the hole", that is to say, we lost $5000 on that year's operations.

Last year, however, in 1934, we restored the assessment and made up that loss with a little bit over. The net cost per member means the amount of the operating expenses chargeable to the assessment, divided by the number of $13 assessments received. In the year 1932 the assessment was $13 and the expenses were $12.

The next year the assessment was $10 and the expenses a little bit less, $11.80. For the last year the expenses were $10.85, leaving us an appreciable balance which you see analyzed. For the three years, the average assessment has been $12 and the average expenses $11.55, leaving a little leeway for the safety fund and the reserve.

The members very often want to know what becomes of their $13. Some years ago (1930 Transactions, p. 20) I made an analysis of that $15 as it was then. Here I have made again an analysis to show you where the $13 go. The analysis for this past year about concluding, so far as it is possible to take it, is this:

Journal—editing and publishing, but excluding the general office expenses, cost each member $3.75 of his $13.

Dr. Marsh read the analysis of the assessment, which is contained in the Treasurer's Report.

DR. MARSH: I just have received word that $2000 in bills have come in for legal fees, which will cost each member about 66 cents apiece, so that that balance of $2.15 is reduced to about $1.50.

That is the statement I prepared in place of the regular Treasurer's Report. (Applause.)

Action, Sect. 45.

ANNUAL REPORT OF THE TREASURER—JUNE 30, 1935

Submitted on June 30, 1935

PERMANENT FUND

DR.

May 31, 1934—	
2 M 1st Liberty Loan 3½% bonds	$2000.00
2 M 4th Liberty Loan 4¼% bonds	2000.00
2 M U. S. Treasury 3¼% bonds of 1943-5	1997.50
Mortgage Certificates, Investors Title & Mortgage Guarantee Co.	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Co.	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
Deposit in Savings Account	17.50
June 13—	
Profit on sale of 2 M 4th L. L. bonds	50.25
	$15,065.25

CR.

May 31, 1935—	
2 M U. S. Treasury 3¼% bonds of 1943-5	$1997.50
1 M U. S. Treasury 3¼% bonds of 1944-6	1034.38
1 M U. S. Treasury 3% bonds of 1946-8	1014.06
Mortgage Certificates, Investors Title & Mortgage Guarantee Co.	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Co.	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
Deposit in Savings Account	2019.31
	$15,065.25

GENERAL ACCOUNT

RECEIPTS

Balance, May 31, 1934		$30,145.04
Assessment:		
Atlantic	$ 1,651	
Bergen	3,016	
Burlington	702	
Camden	2,041	
Cape May	338	
Cumberland	663	
Essex	10,244	
Gloucester	507	
Hudson	4,979	
Hunterdon	338	
Mercer	2,301	
Middlesex	1,638	
Monmouth	1,492	
Morris	1,248	
Ocean	247	
Passaic	3,155	
Salem	221	
Somerset	767	
Sussex	299	
Union	3,687	
Warren	403	
		39,937.00
Publication receipts		7,423.68
Interest		554.33
Miscellaneous		21.00
		$78,081.05

PAYMENTS

For Publication Committee		$12,280.81
" Salaries:		
Secretary	$1500.00	
Executive Officer	6000.00	
Editor	5000.00	
		12,500.00
" Office:		
Clerical services	$3510.00	
Operating expenses	1106.81	
Furniture and equipment	897.52	
Travel	777.33	
Rent	960.00	
		7,251.66
" Expenses of Officers:		
President	$1271.34	
Secretary	1420.72	
Treasurer	60.12	
		2,752.18
" Expenses of Committees:		
Trustees	$ 119.16	
Welfare	90.38	
Public Health	438.61	
E. R. A.	53.30	
Other committees	76.25	
		777.70
" Annual Meeting, 1934:		
Program and arrangements	$ 557.62	
Credentials	248.77	
Scientific Exhibit	152.61	
Guests	249.46	
Woman's Auxiliary	220.70	
Arts and Hobby Committee	70.05	
		1,499.21
" Printing and stationery		2,776.80
" Legal services and expenses		2,063.02
" Cabinets for Scientific Exhibit		300.00
" Woman's Auxiliary		254.50
" A. M. A. RR. fares		75.83
" Professional conferences		50.00
" Miscellaneous		160.90
Transferred to office cash fund		200.00
Balance, May 31, 1935		35,138.44
		$78,081.05

BUDGET RECONCILIATION

Expected income	$47,000.00
Actual receipts	47,936.01
Budget appropriations	44,410.00
Expenditures	42,942.61
Operating net balance	4,993.40

Respectfully submitted,

E. J. Marsh, Treasurer.

DR. DAVID B. ALLMAN (Atlantic County): I rise to a point of order. I wonder if this would be a good time to bring up the subject of dues while the Treasurer's Report is fresh in our minds, or whether it should come later.

PRESIDENT ELY: I would suggest, Dr. Allman, that we bring it up after the Report of the Budget Committee by Dr. North, which will be called for in a few minutes.

16. EXECUTIVE SECRETARY

I note the presence of Dr. Wilkes, our Executive Secretary. I made a tentative report for him. Dr. Wilkes, would you care to make a supplementary report? Dr. Wilkes!

DR. WILKES: Mr. President and Members: Since the work of the Executive Secretary is a sort of machinery which carries out the recommendations of the President, around whom all activities of the Society revolve, I think that the statement contained in the advance reports, both of the President and the Executive Secretary, show you pretty much the work of the Society for the year.

Since the issuance of that report, as far as the Executive Secretary's work is concerned, it has been very largely devoted to the details of those aims as stated, revolving this last month principally around preparations for the Annual Meeting and for the legislative supervision.

I do not know that there is anything especially to add as an accomplishment of the mechanical department of the Society, since the report was submitted a month or two ago.

17. FINANCE AND BUDGET COMMITTEE

Report, Jour., April, p. 199

PRESIDENT ELY: We will call for the Report of the Finance and Budget Committee—Dr. North.

DR. HARRY R. NORTH (Trenton): Mr. President and Members of the House of Delegates: The Finance and Budget Committee have had three meetings and we have developed a budget which is practically the same as last year. I will be glad to read it to you.

Dr. North read the budget, as follows:

PROVISIONAL BUDGET—1935-1936

Publication		$12,500
Welfare		750
Executive Secretary:		
Salary	$6,000	
Secretary	1,300	
Clerk-Stenographer	1,040	
Office Expense	1,500	
Travel	1,200	
Rent	480	
		11,520
Journal Editor:		
Salary	$5,000	
Secretary	1,300	
Office Expense	500	
Travel	250	
Rent	480	
		7,530
President's Contingent Fund		2,000
Credential Committee		300
Printing		2,000
Treasurer		75
Secretary:		
Salary	$1,500	
Office	1,300	
Annual Meeting	500	
		3,300
A. M. A.		300
Arrangements		600
Secretarial Conference		100
Scientific Exhibit		400
Guests		200
Public Health		500
Emergency Relief		100
Joint Committee Professional Relations		100
Arts and Hobby		50
Woman's Auxiliary		200
Contingent Fund		2,000
		$44,525

For action on the budget and dues, see Sect. 44.

DR. NORTH: Of course, the chief point is what to make the dues. Your Committee feels that we should have each year a small surplus. At the present time, we feel there is a surplus of about $7000. If you wish to use up that surplus and reduce the dues $1, it takes off $3000 immediately. If you do not care to use that surplus and still keep the dues at $13, you may have a surplus next year and may not—I do not know. This committee feels that the dues should remain at $13. That means twenty-five cents a week.

I do not believe there can be very much kick on the dues. I think the Medical Society of New Jersey or any medical society probably pays less in dues than any other society of cults, or the American Federation of Labor, or any society. So we feel that $13 should remain as per capita dues. (Applause.)

DR. ALLMAN: May I say a word?

PRESIDENT ELY: I recognize Dr. Allman, of Atlantic City.

DR. ALLMAN: I do not want to start anything, but I have been elected as spokesman by the Atlantic County delegates to talk about this matter of dues and if I do not do anything else, I am probably going to be the punk that sets off the fireworks.

We have had a lot of discussion about these dues and I have had some talk with Dr. Marsh and the Budget Committee. They have not sold me the idea that I am wrong, so I am

going to read you what I had written and I am still going to maintain that it is correct. May I have about ten minutes for this talk?

President Ely: Yes.

Dr. Allman: I do not want to hurry. If we are wrong, we are wrong. I was President of the Atlantic County Medical Society last year and I think they thought they were conferring an honor on me when they made me Treasurer this year. In the presence of some ladies, bar my opinion of what I think they did to me.

However, I find the average fellows, and we are not the average fellows here—do not confuse yourselves, the average fellows are the young men who do not hold the offices. The average fellow is discontent and thinks the dues are too much. You cannot explain to him the way Dr. Marsh and the Chairman of the Budget Committee explained to you where your dues go. He does not see it that way. When he reads Dr. Marsh's report, he does not see it that way. When they showed it to me, I was pretty much inclined to agree with them.

Dr. Allman read his prepared remarks with the following interpolations:

Preceding the words "What is all this money for? Why should the State Society", etc., Dr. Allman said:

Dr. Marsh tells me $39,000. There will be $2000 off for lawyers' fees that we got roped in for, but at that, it is $37,000 instead of $39,000 as last year. This is in addition to the permanent fund of $15,000 or less.

Preceding the words "By reducing the dues $2 a year, the balance of reserves would not be distributed one iota", etc., Dr. Allman said:

Right here I want to digress because the Chairman of your Budget Committee is going to tell you you do not have that much money and before he tells you you do not, I am going to try to tell you a little later that you do and show you that you do. (Laughter.)

Personally I do not care whether it is $2 or $4 or $5. It does not make any difference to me, fortunately. I was lucky enough to be in a position where I do not care; I really do not. I am not saying it in a braggadocio spirit, but I think we ought to consider the other man and even now we are only an organized minority. If we lose over 200 members a year, as Dr. Morrison said, old members, and we have lost some because they cannot afford to pay, it is wrong if we have $50,000, and we have.

Preceding the words "So we see the figures prove our Board of Directors are in error", etc., Dr. Allman said:

I would like to correct that. The permanent fund—apparently the depression has it. It is not over $15,000 now. It is over $8000 or $9000, anyhow.

Dr. Allman: If I am in order, Mr. President, I therefore move you—I do not know whether I am in order or not, that the dues for The Medical Society for the coming year be made $9. The Chairman of our Budget Committee is going to tell you, and I said before, I do not care about this, I am fighting for the other fellow. It does not make any difference to me. He is going to tell you this $35,000 that Dr. Marsh has now is what Dr. Marsh is going to have to run his society with until the first of January next year when the dues come in. Theoretically, that is all right.

He has got to have that in his pocket, but when he budgets his budget, he makes that budget up from May 31st of this year to May 31st of next year and no matter where the money is, what bank it is in or where it is, his budget says we are going to spend $40,000 from May 31st to May 31st—$40,000.

The Treasurer's statement, and I am sorry we haven't got enough to pass around, is going to show in addition to the $35,000 we are going to get $38,000 from dues, $7000 from the Journal and miscellaneous expenses sufficient that at the last budget issued, we had $24,000 on hand on May 31, 1933, and what he collected in dues and from the Journal, and everything else, brought the grand total up to $71,000.

Out of the $71,000 during that fiscal year—I do not care whether you figure for six months, he hasn't any money, the other six months he has it all—all he spent out of that $71,000 from May 31st to May 31st was $41,000 because he had a balance at the end of $30,000, or $5000 more than he started with. That was last year.

This year he is going to have the same thing, $5000 this year more than he started with. He started with $30,000 last year. When he gets through this year he is going to have $35,000. He just said so. You all heard him. If the dues keep on the way they are going, next year he is going to have $40,000 and the next year $45,000.

The Chairman of your Budget Committee is going to tell you that is what you have to run your Society on. I do not give a whoop whether you do or not. If you are going to have twice that much afterward, don't pay the bills until the first of January. My patients don't! (Laughter.) Don't let the Society.

If the Society does not have to pay any bills until the first of January, on the first of January or at least between the first and May thirty-first, the doctor is going to take in over

$5000 more than the budget is. I again maintain we ought not in these times be operating at a net profit. I think it is a fine thing to have a little reserve, as the doctor says. He said a reserve of $7000. If that is all you have, I would not think of cutting it out. But it is not all, gentlemen. He is trying to figure from January to January, and I say this with all due respect, it is all in fun, but it is true, he figures from January to January and Dr. Marsh figures from May 31st to May 31st.

You cannot fool all the people all the time. We are making $5000 a year at this much dues and we have $35,000.

DR. MARSH: Yes.

DR. ALLMAN: At the end of the year, and $15,000 in the permanent fund. (Applause.)

PRESIDENT ELY: Dr. North, would you care to say something?

DR. NORTH: Yes, I would like to say a few words. It won't be necessary for me to say what I was going to say because Dr. Allman said it about four times already, so you know what I was going to say.

In the first place, Dr. Allman says there is a general persistent demand for reduction of dues. I have heard there has been some demand. In my county we have 175 members. There isn't a single man that I know would kick about the dues. That may be quite true in some counties, I do not know. If a man cannot pay $13 a year, he cannot pay $12 and he cannot pay $11. Even if you could get it down to $9, I do not see if he can pay $9 why he cannot get together $13, if it is necessary.

It is quite true that these figures Dr. Marsh has are somewhat misleading. All I know is this—before we made up this budget I went to Dr. Marsh and asked him what our surplus would be this year after paying out these $2000 of legal fees. Dr. Marsh tells me the surplus will be $7000. I cannot go beyond that. I do not know. I do not keep the books of the Society. If that is true that we have a surplus of $7000, every time you take off $1 from the dues, it takes off $3000 of our surplus. If you make the dues $11, your surplus is gone.

This year, I told you, the budget was $44,-524 and you get about $39,000 in from dues and about $7000 from your publications and so on. So, according to Hoyle, we are really giving you a budget of just what you are taking in.

We are more than glad to suggest any dues that are reasonable and for a long while we considered reducing dues to $12 and then felt we could not even do that. If it can be done, all well and good. The State Society, I understand, has lost 200 members. If the County Societies of this state would do like Mercer happens to do, you would not lose 200 members. If a man in Mercer County cannot pay his dues we pay them for him. Fortunately, in Mercer County we have been very careful for many years past and have built up there a reserve of our own which amounts to something like $15,000. No member in Mercer County is going to resign because he cannot pay his dues.

Suppose 200 members cannot pay dues among 3000. It is too bad the 3000 cannot chip in and pay for them. I do not think any man should be compelled to drop out because he cannot pay dues. Certainly he is not going to stay in because you reduced the dues $2. If he is as close as $2, he is going to be out, anyway. We still feel the dues should be $13.

PRESIDENT ELY: The subject is open for discussion if any other member cares to make any remarks. Now is the opportunity.

DR. EAGLETON: I want to recall a piece of State Society history. If you want to have a strong organization that is going to do anything for the doctors, you have to have money and to spend money. The dues of this society in the year 1920, if I am not mistaken, were $4. In the year 1922 (the resolution that Dr. McBride offered about Dr. Costill), the chiropractors went to the Legislature and passed a bill that resulted in the 575 chiropractors being licensed by the State of New Jersey and then we created a Welfare Committee to try to undo that legislation. They were given $1000 and we went to work and before we got through our Welfare Committee, itself personally, owed $4000 for help that it had. Dr. Harvey came to me and said, "What are you going to do about that? I will pay half of it if the Society does not pay it." The Society did pay it.

The following year it jumped from $4 to $8, and it has been going on ever since.

This last year there has been passed one of the most important things that has happened to the medical profession. I do not know how much they are going to receive in return, each individual one. The C. W. A. is paying a large amount of money and if we are going to go on that way, we have got to have these committees have some money because you cannot expect work like what was done by the lawyer. He sent in a bill for $2000. In O K-ing that bill, I said to Dr. Ely, it is dirt cheap for the services he rendered.

You cannot have a strong organization, and we are a fighting organization, without having money. (Applause.)

DR. MORRISON: Mr. President, I would like to make a few remarks on this subject. Because of the reports coming into my office, I felt compelled to make the reference to the

reduction in dues that I did in my annual report, but it is not my personal feeling.

Dr. Eagleton has told you in 1922 the dues to the State Society were $4. Now you got $4 worth of benefit from it. The next year the dues were $8 and you got about $8 worth of benefit from it. Last year the dues were $13 and each individual member in this State Society gets over $50 from it.

You should stop and figure these things out and those of us who are officers have a little better opportunity of doing it than some of the rest of you.

True, we lost 200 members last year, but we have already picked up nearly 250, so that has been wiped out. There is another point you want to settle right here and now. Are Dr. Marsh's figures correct when he says we have $7000 in the fund, or Dr. Allman's figures? Who knows those figures unless it is Dr. Marsh? If Dr. Marsh says we only have $7000, that is all we have.

This year out of a clear sky we did not anticipate a legal expense of $2000. Next year we may have something similar to it. The officers in this Society whose expenses are paid, the President, the Secretary and Executive Secretary—there are other officers who should be paid if the benefits to the Medical Society are to continue, and you cannot do this without funds.

It is ridiculous to claim the doctors in New Jersey are paying large dues. The average dues all over the United States is above what ours is except in the small rural states. The chiropractors pay from $30 to $50 a year. Lawyers pay $30 a year. Druggists pay $18 a year. The laboring man on the street, a member of his labor union, pays $15 a year and what do they get from it? Do they have a law put on the statute books that brings $1,000,000 into their pockets like our Lien Law will?

Do they have an arrangement made with an insurance company that pays them in reduction in dues what they paid the State Society in dues, reduction in insurance, what they paid the State Society in dues? Our biggest competitor in insurance is the Fort Wayne Indemnity Insurance Company. This year it is issuing only one policy, a $10,000 to $30,000 policy. How many of you, especially surgeons or specialists, would feel yourselves safe with a policy of $10,000 to $30,000? It will not issue any more and it has raised the rates on that one. So in our insurance alone the members save more than they save in their dues.

If you want to put a crimp in the work of The Medical Society of New Jersey, if you want to stop the progressive work that has been going on here since 1923, then reduce the dues. If you want this work to continue, if you want the welfare of the State Society taken care of, the welfare of the individual members taken care of, let the dues stay where they are.

About five or six years ago I published a little Blue Book on the advantages of membership in The Medical Society of New Jersey and all these points were brought out. It is about time something of that kind were concocted again, and the financial benefits that the members receive from the activities of this Society were outlined for their benefit. (Applause.)

Just one other point I overlooked—Dr. North referred to the County Societies carrying their delinquent members. Well, the County Societies have from $1000 up to $15,000. What are they doing with it? It is in the bank drawing interest. What are we doing with ours? We are spending it to make the condition of the average doctor better. Why shouldn't the County Societies take care of the few delinquents instead of burdening it on the State Society, where it is a loss to the whole profession?

Dr. Allman: I would like to have the floor another minute because I resent what Dr. Morrison said about taking my figures or Dr. Marsh's.

Dr. Morrison: Let's hear from Dr. Marsh.

Dr. Allman: I said he had $35,000 in the general fund at the end of this year, not surplus.

Dr. Marsh, how much money do you have in the general fund, approximately?

Dr. Marsh: $35,000.

Dr. Morrison: Ask him what the expenses are from that fund.

Dr. Allman: What are the expenses from that $35,000? There are none, are there?

Dr. Marsh: Not from the $35,000; that is at the end of the year.

Dr. Allman: During the year you expect to take in about $45,000 more, don't you?

Dr. Marsh: Yes, about $45,000.

Dr. Allman: The budget for this year calls for $44,000, so even if they spend all the budget, you have another $1000 at the end of the year.

Dr. Marsh: Yes.

Dr. North: That budget is $44,500.

Dr. Allman: You said, Dr. North, the budget of $44,500 would be just about covered by what we took. We would take the $39,000 in dues and $7000 from the Journal. That is $46,000. $1500 you had ——

Dr. North: $500 more.

DR. ALLMAN: Besides some things—you have other incomes besides the dues and the Journal.

DR. MARSH: A few hundred.

DR. ALLMAN: Dr. Marsh didn't say he has $7000. He says he has $35,000, and you are wrong, Mr. Secretary.

I do not care, gentlemen, about this. I realize you cannot run a society without money and I think we should have it. I think we should have plenty of money, but I do not think we need $50,000. I do not think you ought to cut down your activities a bit. We won't have to cut down the activities. I maintain you can reduce it to $9 by simply eliminating profit, cutting the $35,000 down to $30,000, and you will be able to do everything next year that you did last year and the year before.

I think they are confusing the issue for the State Society has plenty of money. They have $5000 and cannot spend it. They spend $44,000 a year and take in $50,000.

DR. NORTH: Dr. Allman is talking about $50,000 and that is absolutely wrong. He should not talk about $50,000 that we have. You have to remember that on June 1st we will have a balance of $35,000. That $35,000 has to carry us until January 1st so we get more dues in. It is unfortunate that Dr. Marsh runs from June to June and some of us run from January to January.

The whole thing is this—How much does it cost to run the Society a year, and how much do we spend and how much do we save a year? Another year we pick up $5000. Dr. Marsh tells me he had about $9000 surplus this year and $2000 was spent for legal bills. He tells me this year our total surplus will be about $7000. That is all I know.

I would like to have Dr. Marsh elucidate a bit. If that is true, that we have $7000, then certainly we cannot afford to reduce the dues very much; if we do our surplus is gone and any good business house has to have a little money ahead.

PRESIDENT ELY: Dr. Marsh, would you like to clear the situation?

DR. MARSH: I would like to say this much—without expressing any opinion as to how far I sympathize with either one or the other side of this contention—I must say I am gratified to hear Dr. Allman present the first intelligent discussion of a financial statement or budget that has been presented in this Society since I have been Treasurer. (Applause.)

I do not say how far I agree with him or disagree, but I am glad to have his analysis made, at any rate.

So far as the actual condition of the finances is concerned, the only question I have heard that I understand is now asked of me is as to the actually existing condition. There is at the present time in the bank about $39,000. I have not the exact figures here in my pocket. I can get them from downstairs. It is about $39,000. We have these $2000 legal bills that I have just heard of, which leaves $37,000. There will be other expenses between now and the first of June, also a certain amount of income.

I do not know how much Dr. Barkhorn is going to turn over to me this month, but there will be enough expenses and income so, as Dr. Allman has stated, the balance at the end of this year will be about $35,000, at the first of June. That is somewhat larger than it was last June, some $5000.

If you will turn to the report that I made a few moments ago and which you have in your hands, you will see that when we reduced the assessment, $10 per capita, two years ago, we ran $5000 in the hole. The next year the expenses were reduced somewhat. The next year the expense was somewhat less, but we made up that $5000 and a little bit more—$300, I think, above the $5000 we lost.

The point is this: Dr. Allman has stated correctly that at $13 assessment we run something like $5000 ahead each year. When we cut it to $10, we ran $5000 behind. As to the state of the reserve, that is all I can say. That is what the balance is. What the reserve is depends on how fast it is spent and how fast it comes in. The capital or permanent fund has to be left entirely out of the record because unless it were attached in a law suit, it could not be used. It is set aside by the By-Laws for specific purposes and could not be used even if we ran into debt unless some creditor attached it in court. I suppose it could then. But that isn't necessary. In Dr. Allman's figures he simply brought that in, but I do not think he laid stress on that, anyhow.

The question of the reserve is this: If you wish to spend your reserve, you can reduce the assessment appreciably. If you wish to expend it in one year, you can reduce the assessment quite a good deal. If you wish to expend it over a series of years and reduce the assessment relatively less—if you wish to keep the thing as it is now, running level, you can reduce it a little, as Dr. Allman stated.

In the main, his contention so far as the figures are concerned, is correct. The question is chiefly one of policy and that is where the difference of opinion comes in.

Dr. North has quoted certain figures in support of the Finance Committee's idea of the way the Society's finances should be run. Dr.

Allman has quoted certain figures, the same figures, but in a different way, to show what could be done, and either contention is in itself essentially correct. The question, so far as I can see, is one of policy rather than actual difference between the two men.

President Ely: The question is open for further discussion if any other member cares to make any remarks.

Dr. T. B. Lee (Camden County): Mr. President, it seems to me these are rather perilous times for doctors as well as everybody else and in perilous times, I think people rather strengthen their defense than weaken it. It seems to me if we made any change whatever at a time when we might have some sudden demand on our funds, some emergency arise, it would be better to increase the fees and increase our defenses rather than eweakening our position at this time.

I would be very strongly opposed to reducing the fees under present circumstances, and I think this thing might either be taken care of in the way Dr. North has done and which Camden has done to some extent. I think it is a matter of policy, and it would be a very serious thing to lower the dues at this time. (Applause.)

Dr. Morrison: Mr. Chairman, to bring this matter to an issue, I move the suggestion of the Budget and Finance Committee, that the dues next year be $13, be approved.

Dr. B. S. Pollak (Hudson County): A point of order—that cannot be entertained at this moment because it must be referred to the Reference Committee which you have appointed. How can we vote on a question before the Reference Committee has it?

President Ely: It has not yet been referred to the Reference Committee, Dr. Pollak. It will be at the end of the discussion.

If there is no other discussion on this question, it will be referred to Reference Committee "B", of which Dr. Ulmer is Chairman.

For action, see Sect. 45.

18. President-Elect Newcomb and Legislation

President Ely: The time is passing. We still have some committee reports to hear from, but I note we have with us our President-Elect, Dr. Newcomb, and as he was not in the house when I wished to introduce him to the house, I would like him to come forward now.

I may say in regard to hearing Dr. Newcomb, during my year's administration I have been appealed to from time to time over the telephone or in person by different members of our Society as to what we were doing in active legislation. A great deal of the information came through the Essex County group.

It is true that our Welfare Committee was not called upon to do a great deal of active legislation, but there were certain bills that we had to oppose and certain of our legislators asked the question of different members of our County Societies—what do the doctors want in these different bills?

They made the statement that they do not hear from the doctors, but they do hear and receive so many letters and personal communications from the cults and their admirers. I think possibly Dr. Newcomb might speak on that subject—What do we do when there is a bill before the house that we wish to oppose? We send our letters from the executive office, but do our members get busy in appealing to their different legislators in this method of checking pernicious legislation?

Dr. Newcomb, will you come forward and speak on this problem, please? (Applause.)

See Sects. 8 and 36.

Dr. Marcus W. Newcomb (Brown's Mills): Mr. Chairman and Memers of the State Medical Society: I would rather wait until this afternoon at the meeting of the delegates, because I only brought one bill down from my room.

President Ely: If you want to wait, then do so.

Dr. Newcomb: Don't you think we would probably have more delegates here this afternoon than this morning?

Voice: Yes.

President Ely: We will postpone your speech until later.

Dr. Newcomb: Thank you very much. (Applause.)

President Ely: It was suggested as Dr. Newcomb came on the platform that he would rather speak to a larger audience than was present, and possibly more delegates will be here for the afternoon session.

Dr. Newcomb: I might say I hope some of these men from Morris County will be here this afternoon. I hope you will all be here if you have not seen Number 313. I am going to read it to you this afternoon. It is a very vicious bill. They want to admit a man to examination who hasn't even an M.D. degree.

See Sect. 36.

19. Insurance

Report, Jour., April, p. 222

President Ely: The next report will be that of the Insurance Committee, Dr. Frank W. Pinneo, Chairman.

Dr. Pinneo presented the prepared report, as follows:

NINTH ANNUAL REPORT OF COMMITTEE ON INSURANCE

This report supplements our Preliminary Report published in the April Journal (p. 222) to add statistics and thus bring the report up to date, April 30, 1935.

ACCIDENT AND HEALTH POLICY

The advantages reported last year have been maintained, liberalizing disability when not strictly "house-confining", also providing for double the amount of the policy, as sometimes requested, and providing for optional installment premiums quarterly, or even monthly. Two hundred and fifty-one policy holders are divided in counties as follows:

POLICY HOLDERS IN EACH COUNTY

Atlantic County	6
Bergen	21
Burlington	4
Camden	15
Cape May	4
Cumberland	3
Essex	78
Gloucester	6
Hudson	24
Hunterdon	4
Mercer	13
Middlesex	5
Monmouth	4
Morris	12
Ocean	3
Passaic	11
Salem	3
Somerset	5
Sussex	2
Union	24
Warren	4
	251

POLICY HOLDERS DISTRIBUTED BY AGE GROUPS

Ages under 50	143
Ages 50 to 60	65
Ages over 60	43
	251

The Accident & Health Policy is written by the National Casualty Company of Detroit, and the experience of the year has further substantiated its past record for financial reliability. The liberal interpretation of disabilities has proved that there is such a thing as settlements by an insurance company without resort to technicalities or straining legal points of advantage. The service rendered by the Blanksteen Agency, Jersey City, shows interested desire to serve our members and has been regularly manifested by promptness in settlements.

AUTOMOBILE INSURANCE

An outstanding feature of the year's work has been the increase in number of policy-holders from 953 to 1428, an increase of 50 per cent in one year. There are six cases in process of suit and four other suits have been satisfactorily settled.

Total premiums written	$41,621.01
Premiums earned (estimated)	20,810.50
Losses incurred	6,397.81
(Ranging from one for $4,029. to one for $1.50.)	
Loss ratio	24.03%

It is remarked that "the loss ratio for the doctors was extremely low" until one met a death loss which is included in these figures. The Fire & Theft claims were five, ranging from one for $5.90, to one for $167.30.

The unusual provision whereby they offer the service of advice and practical aid in claims of a policy-holder against another party is a notable advantage. It includes gathering data and prosecuting the claim, even to the extent of legal advice and law suit if necessary, all without increased premium.

In conclusion, the committee urges the attention of the members of the State Society to:

1. The unique advantage in our policies that they are the result of our own negotiations for now nine years and not merely regular policies available for everyone.

2. The committee's intimate knowledge of all dealings with our members assures them of care for their interests.

3. The contracts provide group advantages under our control not possible in individual dealings.

BENEFITS PAID TO MEMBERS DURING THE YEAR

Ages under 50	19	claimants,	$4,142.65—	including	$1,532.13	originating	last	year
" 50 to 60	8	"	2,721.43—	"	535.71	"	"	"
" over 60	7	"	2,868.56—	"	1,682.06	"	"	"
Total			$9,732.64		$3,749.90	"	"	"
			3,749.90					
Claims this year (11 months)			$5,982.74					
Estimate on 3 pending claims			343.00					
Total			$6,325.74					

These claims ranged from one week for $25. to 29 weeks for $1300.00.
Loss Ratio—68% (which includes uncompleted losses carried over from last year).

Let us mention one flagrant fault sometimes manifested in a claimant not heeding his own obligation in the contract to report claims promptly. This has not vitiated a single claim, but it might, were it not for liberal treatment by the agency. This is appreciated but cannot be guaranteed if abused by claimants.

(Signed) Frank W. Pinneo, Chairman,
Barclay S. Fuhrman,
Wayne W. Hall,
Edmund N. Huff,
A. Dunbar Hutchinson,
Warren D. Robbins,
Chester I. Ulmer,
George T. Tracy,
Committee.

DR. PINNEO: This service of the agency in providing legal advice is so unbelievable by our members that they cannot appreciate it. One instance just recently culminated will illustrate its value. A claimant received in a law suit $2000 for which he did not have to pay $1, the agency furnishing the data and the legal advice and the court costs. (Applause.)

PRESIDENT ELY: This report will be referred to Committee "B"—Dr. Ulmer, Chairman.

Action, Sect. 45.

20. PHYSICIANS' LIEN LAW

Report, Jour., April, p. 209

We will hear the supplementary report from the Committee on Physicians' Lien Law. Dr. Weigel, have you a supplementary report to make?

DR. ELMER P. WEIGEL (Plainfield): Mr. President, the final report of our committee was published in the April edition of the Journal, page 209, and we have had nothing further since then.

PRESIDENT ELY: Thank you, Dr. Weigel.

Action, Sects. 45 and 51.

21. CONSTITUTION AND BY-LAWS

Report, Jour., April, pp. 199 and 202

The Committee on Constitution and By-Laws, Dr. Murn.

DR. MORRISON: There is no report.

DR. FREDERIC J. QUIGLEY (Union City): Under Constitution and By-Laws, would it be proper to introduce an amendment? This amendment has been submitted to the Committee on Constitution and By-Laws in conformity with the provision, and I do not know whether you would wish it to be presented now or presented this afternoon under New Business.

PRESIDENT ELY: I think it would be well to present that under New Business, Dr. Quigley.

See Sects. 37 and 54.

The Treasurer's Report, Publication Committee, Finance and Budget Committee, Insurance Committee, Committee on Physicians' Lien Law, Committee on Constitution and By-Laws—all those reports are referred to Committee "B"—Dr. Ulmer, Chairman.

I note the time is approaching the hour of noon and rather than call on other committees, at this morning's session, I think it might be well to consider adjournment until two o'clock this afternoon.

DR. QUIGLEY: I move we adjourn until two o'clock. There is lots of business to come up this afternoon.

PRESIDENT ELY: I think reassembling at two o'clock would be a very good hour. We are closing rather early, and rather than take up New Business at this late hour, we will meet at two o'clock this afternoon in this room.

The meeting adjourned at twelve o'clock.

TUESDAY AFTERNOON SESSION, APRIL 30, 1935

The meeting convened at 2:30 o'clock, President Ely presiding.

PRESIDENT ELY: We will resume the reports of committees.

The first committee report this afternoon will be that of the Committee on Scientific Exhibit, Dr. John W. Gray. While we are waiting for Dr. Gray, we will ask for the Report of the Committee on Art and Hobby, Dr. William K. Campbell.

Dr. Campbell was not present.

PRESIDENT ELY: Delegate to the American Medical Association—Dr. John F. Hagerty.

Dr. Hagerty was not present.

PRESIDENT ELY: The Committee on Councilors, Dr. C. C. Beling. I recognize Dr. Beling, for the supplementary report on the District Councilors.

Dr. Beling had no supplementary report.

PRESIDENT ELY: The three committee reports will be referred to Reference Committee "C"—Dr. Edgar A. Ill, Chairman.

The Committee on Public Health—Dr. Stanley H. Nichols, Chairman.

Dr. Nichols was not present.

22. COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

PRESIDENT ELY: The Committee on Hospitals and Medical Education—Dr. Harry M. Satchwell, Chairman.

DR. SATCHWELL: Mr. President, this committee did not file a presessional report this year, and so this is the only, or final report.

Dr. Satchwell presented his prepared report, as follows:

REPORT OF THE COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

To the House of Delegates:

This report is for the academic year ending June 1, 1935, and as in previous years is submitted in two parts, one the report of the Sub-Committee on Education—Dr. Dan Renner, Chairman; and the other the report of the Sub-Committee on Hospitals, of which Dr. Charles Kelley is Chairman.

PART ONE—MEDICAL EDUCATION

The same plan was followed as in previous years, namely:

1. Lecture courses were given in various centers established in previous years and along lines determined by this committee in coöperation with the Extension Division of Rutgers University.

2. After a conference between the Chairman, Dr. Renner, and Professor Norman Miller, Director of the Extension Division, it was decided that the plan of previous years would be carried out as follows:

a. Courses would consist of six lectures each and that the fee for the first and subsequent courses would be fixed at $10.00.

b. That the fee paid to each lecturer would be $25.00 in addition to traveling expenses.

c. That a minimum quota for each county group would be set at 25 subscriptions.

d. That where the income exceeded $350.00 the county committees would be allowed to retain the excess which was to be used for educational purposes or for rebating of the $10.00 subscription fees.

POST-GRADUATE COURSES

As shown in the chart which is a part of this report, courses have been or are being given in nine centers. Last year courses were given in ten centers, and in the previous year in thirteen centers. The reason given for not holding courses in those centers for the past two years has been lack of interest.

Courses were given in diagnosis, medicine, surgery, pathology, endocrinology and dermatology. Details of the courses are shown in the chart attached to this report.

COLLATERAL ACTIVITIES

1. This committee was requested by the Committee on Public Health to set up courses on public health subjects as part of its educational program. In arranging the program for this year this committee has kept this request in mind, but has found that lectures of this type either singly or as courses are not saleable to the various county groups. In March we secured Dr. Bela Schick as lecturer on diphtheria immunization for the Somerset County Society at its monthly meeting. Last year a similar lecture by Dr. Schick was arranged by us for the Essex County Medical Society and was followed by a demonstration of technic and results of the Schick and Mantoux tests. Also we arranged for the Bergen County Society a course of six lectures on Public Health Subjects. This was in coöperation with the Bergen County Tuberculosis League which partly financed the course.

2. As in past years, we were allowed to recommend two students for the three-year half-time surgical course given by the New York University Medical College in its division in Bellevue Hospital under the direction of Dr. Arthur Wright. This year this privilege has been extended to six students to start in September, 1935.

3. Your committee, through the Essex County Committee, arranged two courses for the dentists of the county, one in therapeutics and the other on interpretations of clinical pathology. Both courses were well attended and I have been requested to repeat the courses next year.

4. Six men have been placed as students in the Cardiac Clinic of New York Beth Israel Hospital under the supervision of Dr. Harry Gold.

5. A course of ten monthly lectures on heart disease has been arranged for the Essex County Heart Commission as the scientific portion of their monthly meetings. These lectures have been didactic in character and have been given by members of our State Society faculty and have been paid for by one of the members of the Commission. There has been an average attendance of fifty at each lecture. A course in child psychology by Dr. Plant, of Newark, was arranged for a group of pediatricians of Essex County. This group numbered twenty-five. The subscription fee of $15.00 was paid by the members of the group. The course consisted of twelve lectures.

6. This year in Essex County two courses were arranged of six lectures each, one in medicine and the other in pathology. On account of inability of the interested members of the Society to furnish enough subscriptions to finance both courses at the $10.00 fee, one course was given as part of the State Society activity in coöperation with Rutgers, and the other was given by the County Committee as an extra curriculum course. The first was attended by fifty-four and the second by sixty at a fee of $5.00 for two courses.

7. In accord with the policy decided upon last year to create opportunities for courses of a clinical character, your Chairman has had many conferences with Dr. Raymond Allen, Associate Dean of Columbia University Medical College in charge of Graduate Studies. It was suggested to Dr. Allen that the courses be given in the Post-Graduate School of Columbia and the Extension Division be made more clinical and less didactic. Your Chairman learned that that was the aim of Dr. Allen and he can say that during the past year the courses given by that University have been more clinical in character than in the past, and will be

POST-GRADUATE MEDICAL PROGRAM

Conducted by
THE MEDICAL SOCIETY OF NEW JERSEY
in co-operation with
RUTGERS UNIVERSITY EXTENSION DIVISION
1934-1935

9 Centers — 10 Groups

Centers and Courses	Doctors	Internes	Total Individual Class Registrations
1. Atlantic City (Atlantic and Cape May Counties)			
1. Recent Advances in Diagnosis and Treatment	59	11	70
2. Camden (Camden and Gloucester Counties)			
1. Medicine and Surgery	69		69
3. Hackensack (Bergen County)			
1. Pathology	27	5	32
4. Jersey City (Hudson County)			
1. Applied Physiology	52		52
5. Newark (Essex County)			
1. Pathology	54		54
6. Perth Amboy and New Brunswick (Middlesex County)			
1. Medicine and Surgery	43	3	46
7. Skillman Village, Marlboro, Morristown, Trenton (Somerset County)			
1. Endocrinology	41		41
8. Somerville (Somerset County)			
1. Dermatology and Medicine	25		25
9. Trenton (Mercer County)			
1. Medicine	24		24
2. Surgery	16		16
	410	19	429
EXTRA-CURRICULUM COURSES			
Essex County Heart Commission	50		
Essex County Committee, Child Psychology	25		
Essex County Society, Medicine	60		
Bergen County Society General Medicine	25		
	160		
		Grand Total	589

even more so next year. Several courses which this committee thought were of special value to the men of New Jersey were announced in the Journal. Your committee believes that these courses will be of sufficient clinical value in the near future to warrant an insert recommending them being placed in the announcements mailed by Columbia to the men in New Jersey. During the past year 150 New Jersey medical men have taken advantage of Columbia courses at the Post-Graduate School and at Mt. Sinai Hospital, New York.

Dr. Allen received very kindly our suggestion that ward-teaching courses be set up in the various hospitals which were not connected with teaching institutions. It was found after conferences with Dr. Benjamin Watson, Director of Sloan Maternity, at which your Chairman had requested that a three years half-time course in obstetrics and gynecology be organized at Sloan, that it would be impossible to fit graduate students into the hospitals teaching under-graduate. This was confirmed by conferences with heads of other medical institutions. During the coming summer for a period of two months Dr. Watson has agreed to take two men recommended by this committee on a half-time basis for obstetric teaching. This activity will be experimental and if found practicable will in all probability result in a curriculum course for graduate students at that institution.

Before my request to Dr. Allen, he had been attempting to arrange short bed-side courses at one of the New York hospitals. After conference of your Chairman and Dr. Allen with the department heads of one of the New York non-teaching hospitals twelve weeks half-time courses in medicine, obstetrics, surgery and gynecology were arranged for practicing physicians. These were to start in December and just as we were about to announce the courses in the Journal the hospital management found that their financial situation would not allow such an activity and the courses were cancelled. Your Chairman feels that next fall he will be able to definitely announce the organization of such courses.

8. Your Chairman feels that a number of the hospitals in the State will soon be up to teaching grade and hopes to announce several clinical courses at various hospitals in the State next fall.

There is a definite move on foot to start teaching of the men in this State by the doctors of this State at various hospitals that are up to teaching grade. I wish the thing had reached the point where I could make a definite announcement at this time; but I feel that by the fall I will be able to state that one or two of the hospitals have started teaching obstetrics.

9. This committee takes this occasion to commend the Bergen County Medical Society for a course of lectures given by their members at the Hackensack Hospital.

The experience this year indicates that in all probability the saturation point has been reached in these didactic courses, at least in some centers. The committee, however, plans to continue such courses for the county groups that desire them. In New York State the saturation point was reached at the end of five years, after which a recess of several years was taken and then the courses reinstituted. The courses in New York State have been paid for out of the treasury of the State Society.

Your Committee wishes to leave with you as food for thought for the years to come, the advisability of assessing each member of the State Society $1.00 per year, which would cover one course of six lectures in each of ten centers at no further cost to the members.

FINANCIAL REPORT

Each year this committee has made a detailed financial report. This year, on account of the Annual Meeting being held in April rather than in June, we are unable to furnish an accurate financial statement. Such a statement will be furnished later at the end of the academic year and will be published in the Journal.

Respectfully submitted,

H. H. Satchwell, M.D.,
Chairman.

PRESIDENT ELY: The Report of the Committee on Hospitals and Medical Education will be referred to Reference Committee "D" —Dr. A. A. Lawton, Chairman.

Action, Sect. 48.

23. COMMITTEE ON PUBLIC HEALTH

Report, Jour., April, p. 212

I note the presence of Dr. Stanley Nichols. Dr. Nichols, will you report for the Committee on Public Helath?

Dr. Nichols presented a supplementary report, as follows:

PUBLIC HEALTH

As the supplementary addition to its report, the Public Health Committee approves the submission of the following recommendations of its Sub-Committee on School Health Program, Chairman, Dr. Ireland, for the consideration of the House of Delegates:

1. It is recommended that the Public Health Committee of each County Medical Society create a subcommittee of school medical inspectors.

2. It is recommended that there be some standard set-up for the selection of school physicians; that the best procedure is for the State Department of Public Instruction to establish these standards and submit them to the State Medical Society for approval.

3. It is recommended that the program of the State Department of Public Instruction be acknowledged as a foundation for possible activities, which local administrators and physicians may use as a guide for the selection of those items they need in their local program, the State Law to constitute the minimum requirements.

In addition to the three foregoing recommendations of the Subcommittee on School Health Program, the Public Health Committee also recommends a fourth, that Board of Education shall not require a physician to carry on activities other than those in relation to school children.

(*Note*: This recommendation is added because of the growing tendency of Boards of Education to include preschool activities in their program which was forbidden by the State Society several years ago.)

In addition to presenting these recommendations, I wish to attempt to place before this House of Delegates just where the medical profession seems to me to stand in relation to public health in the country and particularly in New Jersey.

I would first like to say that as far as *curative medicine* is concerned, developments along that line will depend on the government Sickness Insurance Law whose possibilities, as far as New Jersey is concerned, are being ably dealt with by Dr. Lewis' Committee on Medical Practice. Please bear in mind that that law, *fully written,* is in the desk of a senator in Washington at this very moment, but has not yet been presented to Congress.

The other field, that of *preventive medicine,* constitutes the field of *public* or *community health,* which this committee has been struggling for the past four years to recover for our members in their own offices. It is to *reverse* the *current* of *preventive medicine back* to the *physician's office,* that the Public Health Hour, Diphtheria Immunization, and Vaccination were established and urged by this committee. As most of you know, we have made a special effort during April, by providing every member of the State Society, through his County Public Health Committee, with letters, designed to help him get his own preschool patients to his office for these procedures. In this we have been loyally aided by the State and local Health Departments, P.-T. Associations, Public Health Nurses, School Officials, and many other health groups. Our main difficulty *was,* and *still is,* the arousing of *our own members* to the need of *responding* to this service. One-third of our membership *has waked up. One-third more must wake up* within the next few months or the physician will be organized by outside agencies with *power, laws,* and *enormous public funds* for these purposes, instead of retaining control through our State and County Medical Societies. The question before us is a very simple one. I would ask that every member of this

House of Delegates think most seriously about it, present it to his county society, and create definite opinions concerning it because our committee will probably have to ask you some very definite questions about the matter within a very short time. The burning question is *this*: Shall we, the State and County Medical Societies, *organize ourselves, solidly* and *efficiently*, for the *definite development* of the *various fields of preventive medicine largely within* the offices of our 3000 members, or shall we *be organized* for *precisely* these *same services* by other health agencies and thus lose the directional control of preventive medicine? I want to say to you today *in all seriousness* that we *must make up our collective minds* and answer this question before the *Social Security Bill*, which has already passed the House of Representatives, passes the Senate and becomes a law. Fortunately for us, the *Unemployment* and *Old Age Pension Provisions* will cause considerable delay, because of their enormous crushing burdens on the taxpayer and be subject to some modifications. This Bill also carries $43,000,000 for maternal and *child health* and *public health developments*, most of it on a dollar federal, and two-dollar state, subsidy plan. This will amount to probably over $100,000,000 subsidy of precisely *most*, if not *all*, of the fields of *preventive medicine* which we are engaged in recovering for our 3000 member physicians. The *A. M. A. disapproves* of such *subsidies. Our State Society disapproves. You* disapprove of them. *I disapprove* of them. I would prefer that the tax money raised in New Jersey be *spent* in New Jersey, without having to travel to Washington and back. Some of these health funds will get lost, strayed, or stolen in travelling and get into political and other hands enroute. But it is not enough to *disapprove* of these *subsidies*. We can not ignore or laugh off a $100,000,000 nor permit it to fall into improper hands. The Chairman of this committee is a member of the National Child Health Relations Committee of the American Academy of Pediatrics representing Region I, Eastern Canada, the New England and Middle Atlantic States. On February 10 that committee met by invitation at the Children's Bureau, Washington, and were shown, among other things, that if this Bill passed in its present form, depending partly on state action in New Jersey—with *no* state contribution, New Jersey would receive a minimum of *$135,000 a year*. With some contribution and projects set up a possible maximum of between $700,000 and $800,000 a year. Our committee would ask every one of the House of Delegates to have their county societies *seriously consider* "whether *we* shall organize *ourselves* to deliver these preventive services, or whether we shall remain partly *passive* and *lay ourselves open* to be organized by governmental agencies.

If our answer is *"Yes, we will organize ourselves,"* then our physician members *must*, as a group plan to deliver the following services:

1. Regular examination and health advice, once a month, for every baby, rich or poor, in New Jersey.

2. To immunize against diphtheria, vaccinate against smallpox, and probably in the near future, of some type immunization against whooping-cough and possibly measles and scarlet fever early in infancy for every baby in New Jersey.

3. *Examine*, at least *annually*, and *supervise* the *health of every preschool child* in New Jersey.

4. In addition to the supplementary school health services now being offered, each physician at least once or twice annually, to examine the school children in his practice and direct their healthy growth.

5. Integrate ourselves more vigorously into the control of tuberculosis.

6. Develop periodic examination of adults and mental hygienic advice for all age groups.

An enormous program, is it not? I agree with you that it is. Every field that I have mentioned is contemplated and being planned for by other groups in this State of New Jersey and at Washington. After studying this problem I now say in public speeches to any public group with a health program involving *mass health solutions* in New Jersey, answers like this.

To the Maternal Welfare Group—"We, the State Medical Society, offer you 3000 maternal welfare experts *individually* assisting in *their own offices.*" To the group interested in infant welfare, "We offer you 3000 infant welfare physician assistants to your program operating in their own offices."

To the Health Departments and others interested, in the control of communicable diseases, "We offer you as 3000 assistant Health Officers our public-health-minded physicans, operating in their own offices." To the preschool and school groups, "We offer you 3000 preschool examiners and school health family advisors already acquainted with the children you are interested in, working in their own offices." To the Tuberculosis League, "We offer you 3000 assistant tuberculosis case finders", and so on to any group with a health project in New Jersey.

Do you agree with me that this is the proper answer and solution to these very live issues we are facing today? It seems to me that it is. While it may be necessary to develop through our State and County Society some *mass solutions* for *indigents* in *these programs*, we are convinced that those who are *able* to *pay* on *any sort* of *sliding scale* or *any sum whatever* for *any* of *these services*, should be offered any or all of these services in the private offices of our physician members. By *this means only*, can we preserve the private relationship of physician and patient, and *better preventive medical care* for the *children* and *adults* of this State of New Jersey.

Will each member of the House of Delegates bring these questions up for discussion at their next county society meeting, so that when our committee asks the State and County Societies what they are willing to undertake along these lines, as we very likely will need to do so in the near future when this bill passes you will have some *considered opinions* and *definite plans* adapted to each of your counties, and be ready to provide this service demanded in each of your home counties?

We have been through several hectic years in this New Deal in the practice of medicine. Let us *stand solidly* and bind ourselves very *closely together* as an organization quickly, for in this twelve

months to come the issue of medical self-control or governmental control is going to be settled. Our answer as to *how definitely* we are planning to *provide preventive medical service* for the people of New Jersey is going to help settle it.

Stanley Nichols, Chairman.

DR. MORRISON: Dr. Nichols, do you believe your committee has gone far enough in the work of testing for tuberculosis and immunizing against diphtheria to have the State Society request the Board of Education to kindly not receive children in school who have not been so tested or protected?

DR. NICHOLS: Dr. Morrison, I do not think that our experience has shown that we have gone far enough in any of these procedures to make a compulsory demand of that type. In fact, the majority of our committee have come to believe that compulsion is not a permanent solution to any of these health questions, that if we can educate the public to demand these services rather than to compel them to accept them, and if we approach them psychologically from the proper angle, it will be far better—on diphtheria immunization and individual testing of tuberculosis, the Mantoux test and x-rays, and so on—than it will be to make anything compelling.

If we do that, we create at once a wave of resentment against the medical profession, and we think our aims can be better accomplished by education. (Applause.)

PRESIDENT ELY: The report of the Committee on Public Health will be referred to Reference Committee "D"—Dr. Lawton, Chairman.

Action, Sect. 48.

24. EMERGENCY RELIEF ADMINISTRATION

Report, Jour., April, p. 216

We will now hear the Report of the Medical Advisory Committee to the State Emergency Relief Administration—Dr. Hawkes, Chairman.

DR. E. ZEH HAWKES (Newark): The report of this committee was made by its retiring Chairman, just before he left the committee to become a member of the Executive Council, and the report which we have to make now is a supplementary report.

Before making the report, I would like to say just a few words of appreciation of our ex-Chairman. Dr. Snedecor has served as Chairman of this committee since the beginning of the E. R. A. Medical Service and as Chairman he has always been zealous and unselfish in giving of his time and of his abilities to advance the interests of the doctors of the state.

He has been ready at all times to answer the call to come to various parts of the state and try to help settle their differences and their problems. As Chairman, presiding at the meetings, his attitude has been one to endeavor to have every member of the committee express his opinion so that the concluding viewpoint of the committee should be a composite, a harmonious, and, if possible, a unanimous decision.

In leaving the committee, he leaves a vacancy which cannot be adequately filled.

The supplementary report which I wish to make is in the form of a draft of a medical plan and procedure as it has been practiced in the State, but the Executive Committee thought it should be brought to this House of Delegates and be presented with a request that it receive your endorsement. The purpose of this is that the plan may have a more authoritative statewide application.

The plan which I have to present was drawn by the Executive Medical Advisory Committee. The Executive Medical Advisory Committee is only part of the State Medical Advisory Committee and before being presented to you it should be endorsed by the full committee. It has not been so done. The reason for that is that the draft was not completed until Friday of last week and because the plan contains no novelties. It is simply a rather complete statement of the plan as it is in operation. The Executive Committee thought it would certainly receive the endorsement of the full committee and that full committee will meet at five o'clock today in the Green Room to give authoritative endorsement, authoritative recommendation to this plan.

Dr. Hawkes read the plan, as follows:

AGREEMENT BETWEEN THE MEDICAL SOCIETY OF NEW JERSEY AND THE STATE OF NEW JERSEY EMERGENCY RELIEF ADMINISTRATION

The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration enter into this agreement for the provision of necessary medical care to the clients of the Emergency Relief Administraiton for the period ending December 31, 1935. This agreement may be terminated at any time by notice from either the Medical Society or the Emergency Relief Administration. All changes in this agreement must be mutually acceptable.

The following policies shall govern any plan devised by The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration for the provision of medical care to the clients of the Emergency Relief Administration:

1. The preservation of the personal relationship between the doctor and patient shall be held paramount.

Medical relief shall be supplied by the individual physicians, preferably by the patient's own or previous physician, which shall insure free choice of physician by clients.

The Emergency Relief Administration shall not suggest the name of any one physician. It must provide a roster of physicians furnished by the County Medical Advisory Committees from which the patient may make choice.

3. The Emergency Relief Administration may authorize payment for medical care as a special or single phase of relief to a family or individual.

4. The Emergency Relief Administration shall not pay physicians for work in clinics or hospitals; nor shall it pay hospitals for admission clinic charges.

5. The physician shall decide whether the patient requires hospitalization but except in serious emergency the Emergency Relief Administration shall be notified sufficiently in advance of admission to permit it to establish the propriety of accepting public responsibility for hospital charges. When a patient enters a hospital, all fees to a physician cease so far as that particular patient is concerned. Free choice of hospitalization in any accredited hospital shall be permitted when in the opinion of the physician hospitalization is necessary.

In obstetrical cases no deliveries shall be undertaken in homes where conditions and surroundings, in the opinion of the attending physician, are not consistent with good obstetrical practice.

6. Only emergency cases shall be certified for operation. Elective operations shall not be authorized for relief clients.

7. Only regularly licensed doctors of medicine shall be authorized to treat clients. This clause shall not, however, interfere with necessary treatment which may be given by registered visiting nurses, under medical direction and supervision. It shall not be the policy of the Emergency Relief Administration to substitute midwives for physicians in obstetric cases.

8. Payments by the Emergency Relief Administration for pharmaceuticals shall be limited to the U. S. P., N. F., N. J. Formulary, and such supplementary lists of drugs as may be agreed upon by the Emergency Relief Administration and the Executive State Medical Advisory Committee. Rare exceptions to this rule may be made only upon recommendation of the County Medical Advisory Committee. Physicians should use the less expensive drugs whenever possible.

9. Emergency Relief Administration payments for services rendered by physicians shall be limited to care that it rendered in accordance with the State-wide uniform procedure devised by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration under the terms of this agreement.

ORGANIZATION

In order to carry out these policies, the Medical Society of New Jersey shall appoint an Executive Medical Advisory Committee whose functions shall be:

1. To establish, in coöperation with the State of New Jersey Emergency Relief Administration, a uniform State-wide procedure for the provision of medical care.

2. To aid in organizing County Medical Advisory Committees.

3. To interpret the agreement to physicians, to local Medical Societies, to County Medical Advisory Committees, and to the public at large.

4. To meet with designated officials of the Emergency Relief Administration to consider jointly problems that may arise and their interpretation under the agreement.

There shall be appointed by the County Medical Society in each county where the agreement is to become operative, a County Medical Advisory Committee whose functions shall be:

1. To provide a list of licensed physicians eligible to treat Emergency Relief Administration clients.

2. To review the medical reports made monthly by physicians and to approve or disapprove these reports.

3. To control Emergency Relief Administration medical practice in their respective counties.

4. To serve in medical matters in an advisory capacity to their County Director and in general to have the same relation to the County Director as the Executive Medical Advisory Committee has to the State Director.

The Executive Medical Advisory Committee, together with the Chairmen of the respective County Medical Advisory Committees, shall constitute the State of New Jersey Medical Advisory Committee. They shall meet subject to call to review actions of the Executive Medical Advisory Committee and to discuss whatever problems may arise.

The plan nominally lasts only for one year. It is a continuous plan, but is subject to renewal the first of January in each year.

The attached procedure is subject to change at any time by an agreement between the Executive Medical Advisory Committee and the Emergency Relief Administration.

.....,

President of The Medical Society of New Jersey

.....,

State Director, State of New Jersey Emergency Relief Administration

Date: .....

Then Dr. Hawkes read the procedure, as follows:

PROCEDURE FOR THE PROVISION OF MEDICAL CARE TO CLIENTS OF THE STATE OF NEW JERSEY EMERGENCY RELIEF ADMINISTRATION

The agreement between The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration permits Emergency Relief Administration funds to be paid to individual physicians for services rendered in accordance with the uniform procedure provided for in the agreement. Under the terms of this agreement the procedure detailed herein has been established. Changes in this procedure may be made only by the joint action of the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration.

1. All authorizations for medical care shall be issued in writing on the regular Relief Order blank in triplicate, one copy to be kept by the physician. Telephone authorizations must be immediately followed by a written authorization. No medical service will be paid for unless covered by a written authorization.

If, on an order for medical care, the physician finds more than one member of the family ill, all patients shall be cared for and only one call charged for by the physician.

2. Authorization for emergency service rendered by a family physician may be provided, if the physician reports in writing to the Relief Administration within forty-eight hours the name and address of the sick indigent person, and the occasion for the emergency visit. Such cases are to be considered as exceptional and the approval, if given, shall be conditioned upon the acceptance by the Emergency Relief Administration of the indigency of the patient to whom such emergency service is given.

3. Authorizations for medical care will be issued on an individual case basis. The initial authorization shall be limited to one visit. Subsequent authorizations for continued treatment of a patient, issued at the request of the physician, shall be limited to a maximum of three visits on any one authorization.

4. Medical care for prolonged illnesses, such as arthritis (chronic), and chronic heart disease, shall be authorized on an individual case basis and shall be limited to not more than one visit per week for a period not exceeding one month. Authorization for the further treatment of any chronic case may be authorized only after a review of each case by the County Medical Advisory Committee and each further authorization so granted shall be limited to a period not exceeding one month.

5. Physicians whose names are on the approved list must be classified as either general practitioners or specialists. If a physician is classified as a specialist, he will be paid only for cases referred to him by other physicians for the treatment of cases in his specialty. A physician listed as a specialist is not eligible to receive payment for general medical practice. Neither is a physician who is listed as a general practitioner eligible to receive a specialist's fee for services rendered as a specialist.

6. Physicians treating Emergency Relief Administration clients must render to the County Medical Advisory Committee a monthly report showing the names (in alphabetical order) of patients treated, the diagnosis of each case and the number of home and office visits made during that month on each case. Bills will not be passed for payment by the Emergency Relief Administration until these physicians' reports have been reviewed and recommendations made by the County Medical Advisory Committee.

7. Fees to physicians shall be established for each county by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration. They shall be based upon one-half to two-thirds of the average fees throughout the county. In no case shall the fees paid to general practitioners exceed $1.00 for an office visit, $2.00 for a home visit, and $25.00 for obstetrical cases. (This fee for obstetrical cases shall include all charges for delivery, the necessary pre-natal visits, in no case less than three, and the necessary post-natal care. Details of these services shall be submitted with the bill.) These maximum fees for general medical service shall not apply to fees for specialists that may be established by the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration.

8. It is recommended that $250.00 *per month* be fixed by the *County Medical Advisory Committee* as the maximum to be paid to any one physician for treatment of Emergency Relief Administration patients. County Medical Advisory Committees may, however, modify this suggestion to serve the best interest of the Emergency Relief Administration and the medical profession in that particular county. County Medical Advisory Committees may recommend and the County Director may pass for payment bills from individual physicians in excess of $250.00 when such payment is warranted. When such bills in excess of $250.00 are passed for payment, Emergency Relief Administration Headquarters must immediately be furnished with a statement giving the name of the physician ,the total amount of the bill, the relief month to which it is chargeable, and the reasons for recommending payment.

9. Monthly bills shall be rendered by the doctors to each municipality from which authorization to provide medical care at public expense has been received. These bills shall be rendered in accordance with the standard billing procedure followed by the Emergency Relief Administration for all types of commodities and services.

Doctors must remember to procure the signature of the patient or the head of the patient's family on all authorizations (form E. R. A.—A. 18R), as auditors will not pass bills unless the signature of the client or the head of his family is so affixed.

10. This procedure is subject to change at any time by the joint action of the Executive Medical Advisory Committee and the State of New Jersey Emergency Relief Administration but no changes may otherwise be made.

PRESIDENT ELY: The supplementary report of the Advisory Committee to the Emergency

Relief Administration will be referred to Reference Committee "D"—Dr. Lawton, Chairman.

Action, Sect. 48.

Dr. Eagleton: Before dismissing the subject from this meeting, I would like to call the attention of the delegates to the fact that this matter was presented to the Board of Trustees last night and has their unanimous endorsement. I would suggest, Mr. President, that you ask Dr. Hawkes to give a little resumé.

This is the result of the work of a group of medical men, which is most constructive. I would like Dr. Hawkes in a few words to give a little resumé of how the thing has been operating, how it will operate in the future. He can do it in three minutes as he did, and it will give a much better mental picture to the delegates of the importance of this thing than his long paper which, of course, is necessary in going into all the detail.

President Ely: Dr. Hawkes, will you carry out the request of Dr. Eagleton?

Dr. Hawkes: I do not think, Mr. Chairman, that I can do that.

President Ely: Just give a few summary ideas.

Dr. Hawkes: All the doctors who are doing E. R. A. work know the procedure better than I can state it. They are living it every day. I do think, if you will permit me a few minutes, something ought to be said about the origin of this plan.

Col. Joseph Bigely.—In the spring of 1933, Colonel Joseph Bigely, who lives in Elizabeth, learned that the doctors in Brooklyn were in hard straits. He thought the matter over and he told me that he had had a dream, a vision, that it was not right that men who had spent so many years and so much money in equipping themselves for a life work, should find so much difficulty in making a living and should be driven into other occupations.

He also thought that because the doctor's profession is a quasi-philanthropic one, that it was poor system, poor practice for the state to allow to occur the poor social economics. He thought perhaps the Relief Administration could do something for the doctors. There was no provision in the law. The law simply provided for general relief.

Colonel Bigely took his thought to Mr. Colt, the State Director, and receive his endorsement. He then went to his friend, Dr. Schlichter, in Elizabeth, and presented his thought, and Dr. Schlichter took it to the State Society. A committee was appointed and this committee, acting with Colonel Bigely, who represented the state, formulated a plan, formulated it without any previous pattern, formulated it out of their own view of what should be a proper medical procedure, and formulated a plan which was so fine, so workable, so ideal, that after two years of application, the plan is just as good as it was when they conceived it and before they put it into practice. The only changes have been minor changes that have been necessary and advisable by practice.

I cannot give entirely the names of those on the committee. You know them—Dr. Quigley, Dr. Schlichter, Dr. Snedecor, Dr. Beling, Dr. Green, and Dr. Morrison. It seems to me these men should receive the thanks of the Medical Society, and particularly we ought to take note of Colonel Bigely and his idealistic desire to help us.

I think we might pass a motion of appreciation to Colonel Bigely.

Dr. Quigley: Without wishing to delay this, I would like to say this about this set-up: It is, I think, with a feeling of pride that we can share in this set-up. It was just getting under way during my administration. I have been, naturally, interested to follow it through and I have consulted the majority of State Medical Journals to ascertain the progress of this E. R. A. work.

I think this can be said in all truth, that the State Medical Society, our own State Medical Society has by all odds the best set-up for medical emergency relief of any state in the Union today.

Dr. Morrison: Mr. President, I might also add we have requests from twelve other state societies for copies of our regulations and procedure.

President Ely: Is there anyone present who would like to ask Dr. Hawkes any questions? I think it has been very well covered.

Dr. A. H. Lippincott (Camden): Mr. President, on Dr. Hawkes' suggestion, would it not be well for this House of Delegates to pass a motion thanking Colonel Bigely and Mr. Colt for their pioneer work in this movement?

President Ely: The suggestion is a very good one. Will you make it in the form of a motion?

Dr. Lippincott: Yes.

The motion was seconded.

President Ely: It has been moved and seconded that the House of Delegates go on record thanking Colonel Bigely and Mr. Colt for the interest they have shown in the Medical Society and the doctors of the state.

The motion was put to a vote and was carried.

Dr. Hawkes: The state paid to the doctors of this state about $750,000 last year.

Dr. Eagleton: May I call to the attention of the delegates the fact that work has been

done by doctors who have not received one cent of compensation for what they have done. While the $750,000 has gone to the doctors of this state, the men who have put this in operation and have carried it through themselves have not received one cent of compensation.

PRESIDENT ELY: I may add to Dr. Eagleton's remarks that many times this committee has met once a wek to try to solve the problems that came before them from different parts of the state and they have been able in the majority of instances to satisfy each complaint that came forward.

Action, Sect. 48.

24A. MATERNAL WELFARE

We will advance to the Supplementary Report of the Committee on Maternal Welfare, Dr. A. W. Bingham, Chairman. (Report, Jour., April, p. 210.)

Dr. Bingham was not present.

PRESIDENT ELY: Is any member of his committee present who would like to report?

There was no response.

24B. MEDICAL EXAMINERS

PRESIDENT ELY: The Board of Medical Examiners, Dr. James McGuire. (Report, Jour., April, p. 225.)

Dr. McGuire was not present.

PRESIDENT ELY: The Report of the Public Health Committee, the Committee on Hospital and Medical Education, the Advisory Committee of the State Emergency Relief Administration, the Committee on Maternal Welfare, and the Medical Examiners will be referred to Committee "D"—Dr. Lawton, Chairman.

Action, Sect. 48.

25. WELFARE COMMITTEE

Report, Jour., April, p. 203

We will hear from the Welfare Committee. Dr. Thomas Lee, have you any supplementary report?

DR. LEE: No supplementary report.

25A. SUB-COMMITTEE ON LEGISLATION

PRESIDENT ELY: The sub-committees on the Welfare Committee. First I will call on Dr. Leo Haggerty, on Legislation.

DR. WILKES: Dr. Haggerty asked me to state his supplementary report will be referred to the Reference Committee tonight to bring it up. He is attending Dr. Costill's funeral with several other Trenton men, and will not be here tonight, but his report will be submitted to the Reference Committee.

(See Sect. 36A.)

26. SUB-COMMITTEE ON MEDICAL PRACTICE

PRESIDENT ELY: The Sub-Committee on Medical Practice, Dr. Thomas K. Lewis.

Dr. Lewis presented his prepared report as follows:

REPORT OF SUB-COMMITTEE ON MEDICAL PRACTICE, 1935

During the current year the *New Jersey Formulary*, which was recommended at the 1934 meeting of the House of Delegates, has become an accomplished fact and is now ready for use. It is recommended that:

1. The physicians of the state give this very excellent group of preparations of new and non-official remedies support by wide use. (Your attention is called to the display of these new N. J. F. preparations that will be found in the scientific exhibit.)

2. The profession as a whole use where possible preparations found in the U. S. P., the N. F. and the N. J. F. in preference to proprietary remedies.

The Committee on Medical Practice recommends that *advertisements* in our official publications, whether county or state, be compatible with the dignity pertaining to our profession and, further, that advertisement of lay organizations operating in competition with physicians shall be excluded. (In justice to our State Publication Committee it should be stated that several of the objectionable material will no longer be accepted.)

The Committee recommends that the present set-up for medical service under the *Emergency Relief Administration* be perpetuated at the termination of the present emergency as a means of providing satisfactory and economic medical service for the indigent in normal times.

We wish to report completion of the organization of the *Conference of Allied Medical Professions* during the past year. This organization is composed of representatives of the organized physicians, dentists, nurses and pharmacists of the state. It consists of a state conference with three representatives from each of the state societies concerned and a group in each county with one representative from each group. The object of this alliance is both for the purpose of obtaining concerted legislative power and also for the interchange of ideas with regard to public health matters and common economic problems.

During the early part of the year the Sub-Committee on Medical Practice was urged to prepare a plan in anticipation of possible legislation compelling the adoption of compulsory health insurance. After careful consideration and influenced by information purporting to emanate from reliable sources close to the administration at Washington assuring us that such legislation in the near future was unlikely, the committee concluded that formulation of any insurance plan was inadvisable for the present. The enormous task of working out in detail any such plan would seem a futile expenditure of effort in view of the fact that already a number of such plans, notably that of the Michigan State Medical Society, have been propogated which, with minor adjustments,

could be utilized in an emergency. It seemed a much more profitable proposition to undertake the vastly more important task of finding some means of adjusting modern medicine so that, without lowering its quality or the solidarity of the doctor's economic position medical service might be purchasable by members of the low wage earning class; as well as the task of so perfecting the organization of the profession that it will in any eventuality be prepared to assume the management of all types of medical service.

Certain recommendations have been made and were published in the April issue of the State Journal. Since the effective application of the recommended measures revolve about certain features of the Washington, D. C. plan, with the permission of the chair, we will attempt to explain the operation of this plan, the object of which is not only to overcome dispensary and free ward abuses but also to assist members of the low wage class, who are employed, to meet the cost of medical care on a fair basis compatible with the family budget. The delegates have been supplied with copies of a graphic outline of this plan. If you will refer to these charts we will endeavor to explain briefly the operation of this plan.

The Plan at Washington, D. C.

Obviously, the application of such a plan in toto can only be accomplished in large communities and in communities where there has been some attempt at organization and co-ordination of all charities. The pre-existing centralization of charities in Washington has made that city an excellent field for experimentation. However, the important features of this scheme can be carried on with various modifications in almost any community. Those essential features are the economic investigation phase of the Central Admitting Buraue and the Medico-Dental Bureau. The first of these establishes the eligibility o fan applicant for free service or for special fee consideration recommended for the employed members of the low wage class. The Memidco-Dental Bureau can assist, in coöperation with the professional man, in making suitable fee adjustments and in arranging for collections.

Whether the profession chooses to foster such a plan as the above or whether it will eventually undertake the operation of a straight insurance plan, more perfect organization of the county unit of our medical societies would seem a most essential step to be taken at once. In each county there should be a permanent central county office, similar to that of the Executive Offices of our State Society. The exact nature of such an office will depend upon the size and population of the county. In our larger counties of metropolitan areas the employment of a full-time executive secretary will be an excellent investment. The smaller and less thickly populated counties can function efficiently with a part-time secretary or by furnishing the present secretary with sufficient clerical asssitance, full-time or part-time, to carry on the increasing amount of activity becoming essential to organized medicine. With such organization we shall be in a position to assume control either of compulsory health insurance or the development of such a scheme as outlined above. (And we might add here that the New Jersey State Dental Society is very much interested in a plan which so closely resembles the one we have outlined that coöperation of the dentists in any such undertaking may be counted on.)

The enthusiasm with which industrial establishments and hospitals have taken up the Washington plan leads us to the conviction that in all communities, large and small, these institutions will lend a helping hand in the maintenance and operation of an economic investigation bureau similar to that incorporated in the Central Admitting Bureau of the Washington plan.

For those individuals who, through adequate economic investigation, have been found eligible for the special privileges of the low wage class the following benefits will be available:

1. Special prescription rates. Some designation on the prescription, determined upon by mutual agreement with the Pharmaceutical Association, will indicate the class to which the patient belongs. (Informal conferences with representative druggists has demonstrated a willingness on the part of the pharmacists to go along with this plan.)

2. Greatly reduced laboratory fees. This will obviate the present necessity for referring many study cases to dispensary and ward, thereby securing some small income to the hospitals for work now being done not only without any monetary return, but also representing a considerable expenditure of money.

3. Special rates for use of electrocardiograph and basal metabolism.

4. Special schedule of fees for x-ray work.

5. Adjusted consultation fees by arrangement with the various specialties.

6. Modified fees for surgery and for medical survey.

It is understood that a suitable card issued by the Socio-Economic Survey Bureau will be essential to qualify any individual for the benefits of such service and that the life of such a card will not extend beyond four to six months after the date of issue. For continuation of benefits after the expiration date reinvestigation will be required.

The following additional recommendations for future development are offered:

1. The development of private wards or the segregation of these reduced rate patients in existing wards for fees between the present semi-private room rates and ward rates, wherein the patient shall have the status of a pay patient and the attending physician or surgeon may collect a modified fee.

2. Voluntary hospitalization insurance for members of the low wage class. It has been worked out that, at most, twenty cents per week will adequately cover the cost. With the hospital bill provided for, the patient will be in a much better position to meet the fee of the medical attendant.

Dr. Lewis: I might state that the whole set-up will be elaborated in great detail at the coming session of the A. M. A. next

month. There are just certain essential features which I would like to bring out at this time.

If you will refer to the second page of this chart the activity of this plan centers around the essential admitting bureau which bureau undertakes a thorough, competent socio-economic investigation of applicants either for charity or for modified service.

Patients appear at this central admitting bureau by way of physicians and dentists, hospital out-patient departments, welfare organizations of certain firms and employers, public agencies, including the F. E. R. A., and private agencies such as schools and health departments.

No patient is refused first treatment at a dispensary, but if such patient requests that his follow-up treatment be carried on there rather than by a private physician, he is instructed to go to the central admitting bureau and if they find him acceptable for free work, he will be given a card which entitles him to return to the dispensary for treatment.

In practical application in Washington up to date, an average of 20 per cent. of such applicants have been returned to private physicians or dentists, having been found able to pay their own way.

Firms and employees have been very much impressed with this because they have been up against the proposition of directing their employees to competent medical service at a price which that individual is able to meet.

Physicians and dentists, in taking care of their private patients, if met with the statement, "Well, doctor, this operation is going to be too expensive," are referred to this bureau and adjustment is made by way of the medical-dental service bureau which you will see in the third rank. The medical-dental service bureau is the organization maintained by the physicians and dentists at Washington for the purpose of coördinating or correlating the individuals' ability to pay and the doctors' fee.

To illustrate what I mean, may I cite one case which was under adjustment at the time we were looking over this set-up in Washington. The individual had a wife who required a major operation. He went to the surgeon and asked how much it would be. He stated that he had a limited income and probably would not be able to pay that for a long time. He was referred to the medical-dental service bureau, from there to the central admitting bureau, where a true picture of his socio-economic status was obtained and then returned to the medical-dental service bureau.

That helped that individual to budget his income and attempted to establish just how much, month by month, that individual could set aside toward the payment of this bill which was about to be incurred.

Having gotten the true picture, the surgeon was called up and was given the same picture and he modified his fee in this particular case from $175 to $65 to meet the pocketbook of this individual, so saving that patient from going by way of the ward which otherwise he would have been compelled to do in order to get this branch of service.

The Community Chest and the Board of Public Welfare are linked up with this outfit and the whole thing is completely controlled by the medical society.

To give you an idea of this way in which industry has taken this matter up, I am going to read one of a group of announcements which are being printed and placed by employers in the pay envelopes of the employees:

"Do you owe your doctor or your dentist? Do you or your dependents need treatment you feel you cannot afford? Are you hesitating because of the cost? At last there is a solution to these problems, a plan for those of us who live on a salary and cannot always have a tidy sum in the bank in case of emergencies.

"The medical-dental service bureau will arrange small regular payments for your medical-dental and hospital bills, old or new. There is no charge to you for this service. This is the medical and dental professions' new plan to help you out through these times of money pressure. Consult Mrs. Sterling for further particulars."

Mrs. Sterling happens to be the social welfare worker in that particular industrial establishment.

Another word about the medical-dental service bureau. This is a collecting agency as well as an agency for adjustment of fees. Having established the monthly ability of the individual to meet this obligation, this bureau sends out a monthly statement, collecting the money, and transmitting it to the physician or the hospital until the bill is cleaned up.

The bureau keeps out 10 per cent. of the monies collected for a dual purpose, first, the maintenance of the bureau, and, in addition to that, for the creation of a sinking fund against unexpected catastrophes, which will be used in this way: John Jones is paying for an appendectomy which has been performed on his wife. When he is partly through the payment, something else happens and one of his children requires a major operation, so the combined load will take him two or three years to clear up, according to his ability to pay.

When such catastrophe occurs, the reserve fund clears up the old doctor's bill and the old hospital bill and starts him off with payment of the fresh plan.

When we were down there, it had just transpired that the hospitals linked up with this plan had requested that the medical-dental service bureau take over for them the collection of unpaid accounts. They have one printed form which any physician can use, which reads something like this: "Your bill has been paid. No doubt it is because of the fact that you are not in a position to meet this obligation in a lump sum. If you will go to the medical-dental bureau they will help you to budget and clear up this old obligation."

The story we received was this: As a result of this announcement any number of bills were promptly paid in full. But in addition to that, a number of patients who had been owing their doctor for some time reported to this bureau and made arrangements for regular monthly payments. Another interesting statement was the fact (of course, this plan has only been in operation some five or six months) that up to date there had not been a monthly remittance passed up by any of these people.

That is a very brief and somewhat sketchy outline of the plan. As I say, the thing will be laid out in detail at the coming meeting of the A. M. A. in the exhibit.

In conclusion, as a result of the fire-works this morning with regard to state and medical dues, I would like to make a few statements: There is no use kidding ourselves about it, we are up against some form of socialization unless we correct conditions ourselves.

No matter what form it takes, if we want a square deal we will have to be in the driver's seat. The activities that are necessary for the accomplishment of this thing mean better and better organization and they require more and more and larger funds and at this time of all times, to think of reducing our reserve and cutting down our contributions to organized medicine is most ridiculous and absurd.

We hear complaints from men who do not understand the significance of what is happening, that is, that dues are too high, and they do not see what they get out of it. It is because they do not know what is going on behind the scenes.

I just want to refer to the remarks made by the Committee on Emergency Relief, the enormous amount of time devoted and personal expense, too, to that work by those men. The least that this organized society can do is to furnish them with secretarial facilities such as we have at the executive office and if we can take home to our societies the urgency for better and stronger organization and a little story about what goes on behind the scenes by those who are interested in state work, I do not think we need worry about reducing our fees. (Applause.)

DR. MARSH: Mr. President, I understand that this plan is operated by the local medical society. May I be told whether it is and if not, what the relation of the organized medical society is to the operation of the plan.

DR. LEWIS: The whole thing is controlled by the medical-dental bureau, is controlled by a committee composed of representatives from the medical society and the dental society.

It would take too long to go through all the details, but if you will refer to the outside sheet, the coördinating committee which controls the activities of the Board of Public Welfare, medico-dental service bureau, central admitting bureau, and everything else, as you see it has five members. When I tell you that four of those members are physicians and representatives of the county medical society it answers your question.

Action Sect. 48.

27. UNIFORM MEDICAL PRACTICE ACT

PRESIDENT ELY: We will hear from another sub-committee of the Welfare Committee—the Uniform Medical Practice Committee, Dr. Samuel Alexander, chairman.

DR. ALEXANDER: Mr. President and Members and Delegates: The Committee on Uniform Medical Practice Act has functioned for the past eighteen months, and I think will require about six months more to bring in its final report. This work of necessity must be slow because it is pionering work. My information is that there is no state in the union at the present time that has a Uniform Medical Practice Act. At the same time we have in this state one of the best medical Practice Acts in the union and we must be careful that we do not do anything that might weaken the present Act.

The committee has three main problems to solve: 1—To set up a standard for all those who wish to practice the healing art. I think we have solved that problem. 2—What to do with those who cannot get a year's internship. We think we have a solution for that. 3—The most difficut problem has been what to do with those who practice the healing art who are not M.D.'s and who desire further privileges.

We have met in the past month with a grou pthat represents hte osteopaths of this state and in discussing the matter with them, they have made assertions that, I think, the

medical men of this state have never met before. In other words, they have taken the position that if we will let the osteopaths who want further privileges and desire to do surgery do so, they will agree to take a two years' post-graduate course in surgery.

For those osteopaths who desire to dispense or prescribe medicines they are perfectly willing to have those osteopaths take an examination by the State Board of Medical Examiners, in materia medica.

I want to say at this time the osteopaths and medical men are nearer together than they have been at any previous time. I am perfectly confident that your committee will be able to present to the Welfare Committee or State Society a suitable Uniform Medical Practice Act and if it meets with the approval of the Welfare Committee, then it will be submitted to the Legislature for its approval. Thank you. (Applause.)

Action, Sect. 49.

27A. Workmen's Compensation

President Ely: A sub-committee to the Welfare Committee—Workmen's Compensation Act Committee, Dr. A. Kraker, Chairman.

Dr. Kraker was not present.

President Ely: The Welfare Committee and the sub-committees that have reported will be referred to Reference Committee "E" —Dr. William H. Areson, Chairman.

Action, Sect. 49.

27B. Woman's Auxiliary

The next committee to report will be the Advisory Committee to the Woman's Auxiliary, Dr. Dan Renner. (Report, Jour., April, p. 227.)

Dr. Renner: Mr. Chairman, there is no further report.

28. Art and Hobby Exhibit

Dr. Ely: Dr. Campbell will report on the Art and Hobby Exhibit.

Dr. Campbell: On January 29, 1935, at 2:00 p. m. in the office of the State Society at Trenton, the Art and Hobby Exhibit Committee held a meeting in conjunction with the Art and Hobby Committee of the Woman's Auxiliary.

It was decided that the Art and Hobby Exhibit should be placed in the hands of the Woman's Auxiliary and that the State Medical Society Committee shall act in conjuction with them.

Mrs. H. D. Corbusier was appointed as Chairman of the Woman's Auxiliary Art and Hobby Exhibit Committee by Mrs. Casselman, the Auxiliary President.

Mrs. Corbusier carried out the work most efficiently, and had full supervision of the preparation of the exhibit room, placing the exhibits, and carrying out entertainment during the session.

One hundred and fifty-two items were displayed by various physicians and their families.

The exhibit was opened on Tuesday evening and was kept open until late Thursday afternoon.

The attendance was quite satisfactory. On Wednesday and Thursday six hundred and seventy-seven visitors viewed the exhibits. Very real interest was shown.

On Wednesday afternoon tea was served to the visitors and a great many participated.

Your committee believes that the arrangement worked out very satisfactorily this year, and we hope that the Woman's Auxiliary will continue the active management of the exhibit and entertainment in the exhibit room next year.

The Committee of the State Society should work in coöperation, in an endeavor to obtain more exhibits. We know that there are many physicians who have hobbies, but from modesty have not been willing to devote the time to preparing an exhibit of their work.

Your committee believes it would be well to have a list made, recording the hobby activities of the membership of the society, so that we may have a source of information as to where we can look for exhibits.

The Art and Hobby Exhibit we believe has provided entertainment and recreation more than sufficient to warrant the small cost involved.

Dr. Ely: This will be referred to Reference Committee "C".

Action, Sect. 47.

See also the report of Mrs. Corbusier to the Woman's Auxiliary, Section 6, p. 74.

28A. Cancer Committee

President Ely: The Committee on Cancer, Dr. Henry B. Orton, Chairman. Have you any supplementary report?

Report, Jour., April, p. 219.

Dr. Orton: There is nothing further.

Action, Sect. 50.

29. Committee on Nursing and Nursing Education

President Ely: The Committee on Nursing and Nursing Education, Dr. Harry H. Satchwell, Chairman.

May I say a word here in regard to this committee? During the last year quite a number of problems arose with a nursing situation within our state. It had been a problem that had been before our State Society and the different individual doctors for several years. It was deemed advisable to make a study of the complaints that were being brought to the different officers in the State Society. So I appointed a committee for this purpose. (Jour., April, p. 194.)

The President and Executive Secretary have had several meetings with the representatives of the nursing group and I may report that they are only too willing to coöperate and be guided by our State Society.

Dr. Satchwell has paid close attention to the nursing situation within our state. I asked him to serve as Chairman of this committee. Therefore, the report. Dr. Satchwell!

Dr. Satchwell presented the prepared report.

REPORT OF THE COMMITTEE ON NURSING AND NURSING EDUCATION

To the House of Delegates:

Last year the report of a study of this activity was submitted as a part of the report of the Committee on Hospitals and Education. Since that time a special committee has been formed which submits this report.

For the purpose of this report, education of nurses can be divided into three parts:

1. Under-graduate education.
2. Post-graduate or further education.
3. University, or higher education.

1. Under-graduate education. By virtue of the Act of 1912, education requirements for training in nursing consisted of one year high school and two years training in a school of nursing. Since that time practically all the schools in the State (36) have raised the requirements to four years high school and three years of training in a school of nursing. Schools of nursing meeting these requirements have been approved by the State Board of Examiners of Nurses. A graduate of these schools after an examination was granted a degree of R. N. In an attempt to secure reciprocity with other states for these registered nurses and to standardize these present requirements the New Jersey State Association of Nurses prepared a bill in 1934 to legalize that standardization. During that year numerous conferences were held with the various nursing groups. One provision of that proposed law provided for two physicians as members of an advisory board, these physicians to be nominated by the trustees of The Medical Society of New Jersey. Up to this date that bill has not been introduced into the Legislature. At this time sentiment in favor of placing two physicians on the examining board rather than on the advisory board is very strong.

2. Post-Graduate Education for Nurses. The various groups of nurses feel that a school of nursing owes a duty to its graduates to furnish Post-Graduate Education. In September of this year one of the hospitals in Newark will inaugurate a fourth year of nursing education. The students will spend part-time at Columbia University, for which they will be given credits towards a degree of B. S. in addition to the credits which they are now allowed as graduates of a three-year school. This will be an experiment and is being done to determine the demand for extended education of this type and also to determine how Post-Graduate students can be fitted into an institution teaching undergraduates. Your committee is taking an active part in the organization and operation of this experimental course.

3. University Education for Nurses. For the past two years the members of your committee have attended numerous conferences of the various groups of nurses interested in higher education. Last fall we attended a conference of those groups with the Dean of the New Jersey College for Women, a Department of the State University. As a result of that conference the League of Nursing Education drew up plans for a five-year course consisting of two years university study and three years study in an approved school of nursing. This five years course was to be given by the State University and a degree of B. S. was to be granted. It was so arranged that there would be no interference with the present three years schools now in existence. This plan of the League of Nursing Education was met by a counter plan of the State University requiring six years of education. This was promptly refused by the League on the ground that the six years was unnecessary as shown by experiments in other states and especially at Columbia University where the five years course is attended by many New Jersey nurses.

Several months ago the attention of the State Board of Medical Examiners was called by several physicians in one of the counties of the State to the fact that nurses of the Visiting Nurses Association were making calls by agreement with the E. R. A. in the place of doctors. The State Board held that this was in effect the practice of medicine by the nurses and ordered the Visiting Nurses Association and E. R. A. to discontinue that practice. As the result of that incident a conference was held between the head of the State Association of Visiting Nurses and Drs. Ely and Wilkes. As a result of that conference this committee was instructed to formulate rules of practice and conduct for nurses working under the Visiting Nurses Associations. This committee has forwarded to Dr. Wilkes a set of rules. These are copied from the rules in use in other states which have been set up by the various State Medical Societies in conjunction with the various Visiting Nurses Associations. A copy of those rules is not included in this report. However, it can be stated that the nurses' powers are reduced to a minimum and that after the first call she must withdraw from the case unless a doctor has been called, from which time she acts under his orders.

Respectfully submitted,

H. H. Satchwell, M.D., Chairman.

Policies Adopted by The Medical Society of New Jersey and the State Organization for Public Health Nursing

A. STANDING ORDERS FOR NURSING CARE

Standing orders may be used in an emergency until a physician can be secured or in the absence of orders from the attending physician.

No treatment except as stated in the Standing Orders should be given without a physician's order.

Any and all of these orders may be cancelled or changed by the attending physician. Standing orders are to be used only where there is no physician in attendance or when previous orders have not been left by the attending physician.

Standing Orders apply only to the first visit of a nurse. A nurse may make a first visit and should urged the calling of a physician. A nurse may make a second visit but if no physician has been called as suggested at the first visit no further treatment shall be given but the nurse shall continue to urge medical care.

If patient's condition indicates need for immediate treatment, every effort shall be made to communicate with the physician at once. Verbal orders given to the nurse should be followed by a written order signed by the physician.

The nurse may not carry out verbal orders given through the family unless verified by the physician.

For New Patients

Urge calling a physician if none is in attendance.
General care as the situation indicates. Instruct family in hygiene of the sick room and care of the patient until next visit.
General care includes bath, care of bed and making the patient comfortable.

For Elevated Temperature—Adult

Urge calling a physician.
Put patient to bed.
Urge importance of rest and quiet.
General isolation routine if communicable disease is suspected.
Liquid diet. Plenty of water.
Sponge for rectal temperature of 102.5 or over.
If patient is suffering abdominal pain, nothing is to be given by mouth until ordered by doctor.

Infants and Children with Elevated Temperature

Urge calling a physician.
Put to bed. Isolate.
Low s. s. enema for constipation.
No enema should be given if there is abdominal pain or tenderness, unless ordered by physician.

For Infantile Convulsions

Have doctor called immediately.
Hot bath with gentle friction of skin.
Low s. s. enema.
Ice cap on head.
Discontinue all feeding.
Boiled water only.

Burns

If burn is severe and there is no physician in attendance, advise removal to hospital.
If burn is not extensive, remove clothing (if not attached to skin); if adherent, do not disturb.
Free portion of clothing may be cut away.
Apply normal saline or wet boric solution dressing on less severe cases.
Call physician.

Earache

No treatment—call doctor.

Discharging Ears

Urge prompt medical attention.
Cleanse outer ear with swabs dipped in boric acid solution.
Do not irrigate.

Dressings (minor)

Urge medical attention.
For minor injuries apply hot boric or saline packs.

Sore Throats and Colds

Urge medical attention.
Isolation.
Plenty of water.
Liquid diet until doctor is on case.
Saline gargle.

Ulcers

Urge medical attention.
Cleanse with warm boric acid solution, or normal saline.
Apply hot dressings either solution, and a firm bandage.

Suspicious Communicable Disease

Isolate.
Boric acid solution for eyes and ears.
Vasoline or cold cream for lips and nose.
Oil rub. PRN for all desquamating cases that have been diagnosed.
Liquid diet.
Sponge for rectal temperature of 102.5 or over.

Obstetrical Cases

In obstetrical cases the following procedures are recommended by The Medical Society of New Jersey. The written approval of individual physicans should be obtained before these procedures are carried out with his patients.

For Expectant Mother

Advise medical care.
See "Health Education—Prenatal and Postnatal".
Apply bandages to varicose veins.
Maternity corset if necessary.
Test urine for albumin. Blood pressure. Report to the physician any unfavorable symptoms.

Preparation for Delivery

General preparation of home supplies and equipment for delivery (bed, dressings, etc.).

Low s. s. enema at beginning of labor.
Clip hair from pubis.
External cleansing of the perineum and surrounding area.

For the Mother After Delivery

Cleansing bath.
Local dressing and external cleansing with one-half per cent lysol solution.
Low s. s. enema, P. R. N.

For the Baby

Sterile dressing to cord.
Oil and bathe.
Soap suppository, PRN.
Keep warm.

Post Partum Hemorrhage

Send for physician.
Elevate foot of bed.
Put patient in elevated Sim's position.
Keep patient quiet and warm. No hot drinks.

B. GENERAL POLICIES IN REGARD TO HEALTH EDUCATION

Health education of adults and children in the home, in the school, in industry and in special group conferences is a legitimate part of the nurse's work. She urges competent medical and dental care and assist in seeing that the instructions and treatment ordered are carried out.

General Health Instruction

As part of her regular duties in clinical bedside care in the home, the nurse has an opportunity to instruct the members of the family concerning procedures for their care when sick; the prevention or dissemination of disease and the general rules for the maintenance of health. In so doing she should neither diagnose nor treat.

The nurses should reinforce the medical or dental opinion given and strive to otain such opinion from the family doctor when not already given.

Hygiene

Instructions under this term should include: *General advice* (fresh air, rest, sleep and exercise, nutrition, cleanliness, recreation and regularity in these habits). *Regulation of diet* in infant feeding and in certain diseases such as diabetes, nephritis, anemia, and in acute illness, call for skilled medical supervision.

Prenatal and Post-Natal Instruction

Urge regular medical and dental supervision for prenatal patients from their first suspicion of pregnancy.
Instruction in the hygiene of pregnancy.
Instruction in the preparation for delivery.
Urge post-partum examination at the time indicated by the physician.

Infant and Pre-School

The nurse should urge continued medical supervision of all children, especially those up to two years of age.

Detection of Defects and Symptoms of Disease

The nurse should urge medical examination for suspected physical defects (seeing and hearing, defective teeth, enlarged glands, malnutrition, faulty posture and others). Her advice must emphasize the necessity of obtaining medical and dental advice on these matters. Th's advice having been obtained, she should stress the importance of having the defects corrected. In the course of her regular duties in bedside nursing and health supervision, she will observe symptoms suggestive of chronic disorders such as cancer, d'abetes, heart disease, tuberculosis or mental disorders for which she should urge the need of medical advice. The importance of early diagnosis and continued adequate treatment must be stressed. In tuberculosis, syphilis, and gonorrhea an examination of all family contacts is essential.

Communicable Disease Prevention

Nurses may give the following advice in regard to—

Smallpox

Vaccination of infants by a physician before end of the first year.

Diphtheria

Immunization at six months of age or as soon thereafter as practicable by a physician or under his direction. A Schick test six months after the immunization procedure in order to determine whether immunity has been established.

Typhoid Fever

Urge medical advice regarding inoculation for travelers, vacationists, and those living in the family of a case or carrier.

Isolation

Coöperation with the Department of Health. Stressing the necessity to the household of observing the quarantine regulations. Select the person who is to take care of the patient and teach her the technic of isolation for the particular disease and environment.

Dr. Satchwell: I am going to ask myself, for your benefit, the reason for this committee. The committee was appointed for a number of reasons: First, to be a bond between the two professions. The second was to attempt, if possible, to secure for the physicians of the state, from the State Society, the control of the medical portion of nursing education. As you know, the doctors at the present time have practically nothing to say about the medical teaching of nurses. That is set up by the National League of Nursing Education.

By putting two doctors on the State Board of Nurses' Examiners, we feel that will be obtained. There are other reasons which come to me quickly—higher education for nurses. It puts us in a position where we can help the

nurses to solve the problem of overcrowding the profession. The higher education, it has been estimated, will open up thirty new types of work for nurses.

As higher education develops, the question of the nurses paying for their education comes along. It is hard to get figures on the cost of a training school to a hospital, but where we have been able to obtain them, it appears the cost per bed per day for the nurses' training school is one-third of the total cost per bed per day of the patient, so it is probably the largest single item of hospital cost.

We feel that the nurses paying for their education will help to eliminate that cost of hospital care. As higher education is developed, the trend toward that higher education is very definite. It has been in the other professions, which, as time goes on, we feel will create a need for organization of a lower type of nurse, the so-called practical nurse who will become a nursing attendant with more training in a hospital.

That is being done in the Western States. There are 10,000 practical nurses in this state who are running at large. They are unorganized. They have practically no training. They are not registered. They are in existence because there is a demand by the public for a low-priced type of nurse. The type of nurse that can probably fulfill all the requirements of home nursing. That problem, to me, is one that will have to be taken care of by the medical profession.

I believe that this committee is fulfilling the function for which it was appointed, to get control of the medical portion of nursing, and I believe that through our spirit of coöperation, what I am going to call gentle pressure, we are obtaining that. (Applause.)

Action, **Sect. 50.**

30. Honorary Membership

PRESIDENT ELY: The Committee on Honorary Membership. Dr. Thomas W. Harvey is the Chairman. I think Dr. Quigley will represent that committee. Dr. Quigley!

DR. QUIGLEY: Mr. President, Dr. Harvey has asked me to present the report of this committee. The entire committee is in agreement on its recommendations. Dr. Mulford, the third member of the committee, expected to be here today, but a telegram was received that he was unavoidably detained and consequently this report does not bear his signature, although it accords with his recommendations also.

Dr. Quigley read the report.

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIP

In conformity with Article IV Section 5 of the Constitution and Chapter VIII Section 9 of the By-Laws, this committee takes pleasure in recommending for Honorary Membership the following members of this Society:

Dr. Wells P. Eagleton, Newark.
Dr. Vanderhoof M. Disbrow, Lakewood.
Dr. Philip Marvel, Cleveland, Ohio.

If it is agreeable to the Chair, we respectfully suggest that a representative of the Essex County Society be given the opportunity to present a brief résumé of the qualifications of Dr. Eagleton; and that a similar privilege be accorded a representative of Atlantic County to present the qualifications of Dr. Marvel, and to the Council of the Fourth District, Dr. James A. Fisher, to present the qualifications of Dr. Disbrow.

Respectfully submitted,
Thomas W. Harvey, Chairman.
Ephraim R. Mulford,
Frederic J. Quigley.

DR. QUIGLEY: Upon the completion of that, the committee would like then to make a motion.

PRESIDENT ELY: You have heard the recommendations made by Dr. Quigley. We will first hear from Essex County, Dr. Barkhorn.

31. Citation on Dr. Eagleton

DR. HENRY C. BARKHORN (Newark): Mr. President and Members of the House of Delegates: I am so thrilled at this privilege that I am trembling a little bit.

Dr. Barkhorn read the report on the honorary membership of Dr. Eagleton.

Wells Phillips Eagleton, Honorary Member of The Medical Society of New Jersey,—Doctor, Author, Philosopher, Teacher, Sociologist, but above all, Humanitarian and Friend of the Doctor! From his earliest youth his interest in people was so manifest that his mother and friends remarked on the fact. His entire philosophy of life has been centered around the thought of loyalty to those who, by their efforts, showed that they were thinking for the good of humanity and the welfare of his chosen profession.

Past President of a half dozen local and national societies and agencies, his ambition has always urged him onward in helpfulness to the younger man and has given him a vision of the social needs of mankind. A cosmopolitan in his point of view with both a national and an international reputation as a scientist and surgeon, he has always presented an outline of his findings to his fellows in this State before disseminating them at large. Because of this, appreciation of his broad learning can best be demonstrated by the esteem and regard we, his professional colleagues, show him.

A fighter for the right, he has been much sought after as a speaker before professional assemblages

here and abroad. He has often, at great personal sacrifice, traveled long distances to spread his knowledge, both scientific and social, thus endearing himself to his multitude of friends and fellow workers. Busy taking care of many seriously sick patients from near and far, he has found time to write over sixty articles and two books, both of which were translated into French, and when the call to service came he immediately enlisted.

It has been aptly said of Dr. Eagleton, "If we had more men like you to hand down the old Hippocratic tradition from one medical generation to the next, we should not have to be afraid of commercialization of our profession." His effort, in season and out, through example and precept to keep the medical profession moored to its high calling, his tremendous energy in stimulating and encouraging the spark of idealism show how much we need him as a staunch warrior to battle on behalf of the profession in these troublesome times. To quote Dr. Eagleton, "The spirit of medicine is greater than any one man's spirit; it is the accumulated spirit of ages of unselfish service. This is our heritage."

We are proud to know a man who is thus holding high the torch for us to follow. In honoring him we honor ourselves. For the Committee on Honorary Membership I present the name of our own Dr. Wells P. Eagleton.

(Applause.)

32. CITATION ON DR. MARVEL

PRESIDENT ELY: I am going to call on Atlantic County, Dr. Conaway!

Mr. President and Members of The New Jersey Medical Society:

Atlantic County presents the name of Dr. Philip Marvel for honorary membership in this Society.

Dr. Marvel was born in Southern Delaware September 15, 1856. His early education was obtained in the public schools of Dover and at the Wilmington Conference Academy in the same town. He studied medicine at the University of Pennsylvania and graduated in 1884. He took a postgraduate course in New York City and also in London, Berlin and Paris. While abroad he had the unusual privilege of studying under the great Pasteur. He began practicing medicine in Atlantic City in 1886. He was associated with Dr. Boardman Reed of this city for a few years and then practiced in the city of Washington for two years, returning to Atlantic City in 1890.

Dr. Marvel was Secretary of the Atlantic County Medical Society for several years, and President of the New Jersey State Medical Society in 1916. He was a member of the Judicial Council of the American Medical Association for three years, and a member of the Board of Trustees of that same organization for eighteen years. Always an internist he devoted his time to the general practice of medicine and contributed frequently to medical journals. During the past few years he was more especially interested in cardiology and his services were frequently desired as consultant by his colleagues.

At the December meeting of the Atlantic County Medical Society he was made an honorary member. We feel that you will be honoring yourselves by electing Dr. Philip Marvel to honorary membership in this Society.

33. CITATION ON DR. DISBROW

PRESIDENT ELY: We will hear from Dr. Fisher.

DR. FISHER: On behalf of Ocean County Medical Society, I wish to present the name of Dr. Vanderhoof M. Disbrow, the oldest practicing physician in Ocean County, who graduated from the University of Vermont Medical School in 1880. The same year he moved into Monmouth County and settled in Farmingdale where he practice three years. In 1883 he moved from Farmingdale to Lakewood and has practiced in Lakewood until the present day.

He has now completed fifty-five years in the practice of medicine. Five years ago Ocean County celebrated his fiftieth year of practice by a testimonial dinner, at which time Ocean County Society elected him an honorary member of Ocean County. Monmouth County felt that as he had been one of the old members of Monmouth County Society, that they would like to do likewise, which they promptly did.

For a number of years he was chief of staff of the Paul Kimball Hospital. He was instrumental in the starting and development of the Paul Kimball Hospital at Lakewood. He has more recently—I won't say more recently—but he has for a number of years been chief obstetrician to the hospital.

We have, as one of our state officers, in the form of a trustee, his son, Dr. Harold Disbrow, and it is with great pleasure that I present the name of Dr. Vanderhoof M. Disbrow. I hope that you will see fit to honor him as an honorary member of the State Society. (Applause.)

DR. QUIGLEY: Mr. President, I move the adoption of the report of the Committee on Honorary Membership, without reference.

The motion was seconded.

PRESIDENT ELY: This report has been received, and it has been moved and seconded that the Report of the Committee on Honorary Membership be voted upon and not referred to a Reference Committee.

The motion was put to a vote and was carried.

34. COMMITTEE ON MEDICAL DEFENSE

Report, Jour., April, p. 221

PRESIDENT ELY: We will continue the reports of committees, and we will hear from the Committee on Medical Defense, Dr. C. C. Beling, Chairman.

DR. BELING: This is a supplementary report to the report that has already been published. The usual statistical tables are unavailable because of the early date of the meeting.

There are now 2234 members insured, as against 1981 last year. We have approximately 75 per cent of the membership of the State Society insured. That is making an allowance for those men who are in institutions, who are members of the Society and who do not take out insurance. There were sixty-three claims. Of these claims, nineteen are open; against ten of them no reserve has been set up because they feel there is no liability and in nine cases the reserve of $3950 has been set up. Thirty-three cases were closed. In seventeen no payment was made. In sixteen a reserve of $8929 was set up. There are eleven cases in suit. Reserve for these is $7381.75. This makes a total of sixty-three cases with a reserve of $20,261 set up.

I wish to make here a comparison of the rates. There is now only one other company that is writing this kind of business in New Jersey, and our present rate for $10,000 to $30,000 limit is $20. In the competitive company the rate is $31. This brings out just what Dr. Morrison mentioned this morning, that the difference between the rates practically equals the annual dues.

For limits of $50,000 to $100,000 our company charges $39.20 and the other company refuses to insure for that amount. In fact, it will not insure for more than $10,000 to $30,000.

In the matter of rates, the insurance company is trying to do its utmost to stave off an increase in cost. They state that the payments and reserves on the 1934 and 1935 business is greater than in any previous year on the current year's business. Whether these present costs are adequate must depend entirely upon the reserves and the further claim experience. They appeal to the committee and also to the members to watch the developments to determine with them beforehand the necessity of increased costs. So far they have not asked us for any increase in rates.

We are hoping to get 100 per cent eventually, and our plan has been to go to each doctor individually and insure him. To carry the work on we ask for the coöperation of the doctors in keeping accurate and complete records, in obtaining more consultation and employing assistance in surgical operations.

We have recently had two cases, one case particularly where a doctor operated upon a case and the operation—well, the patient lived, but the operation wasn't quite successful. That is, there was some deformity in the removal of the tonsils. Part of the soft palate had been removed and this doctor had been operating on the case without a qualified assistant. The committee is planning to make a recommendation to the Hospital Association that when such operations are done some qualified assistant be present or at hand to take charge of the operation if anything happened to the operator. (Applause.)

PRESIDENT ELY: The Advisory Committee to the Woman's Auxiliary, Committee on Cancer, Committee on Nursing and Nursing Education, the Committee on Medical Defense, are referred to Reference Committee "F"—Dr. William F. Costello, Chairman.

Action, Sect. 50.

That ends the Reports of Committees.

35. ALTERNATE TO A. M. A.

I will ask Dr. Morrison to read a letter that we have just received on which we will take action.

Dr. Morrison read the letter from Dr. Marvel, as an alternate delegate to the American Medical Association Convention.

DR. MORRISON: I move the resignation be accepted, with regrets.

The motion was seconded, was put to a vote and was carried. (Sect. 38.)

36. PRESIDENT-ELECT NEWCOMB'S ADDRESS

PRESIDENT ELY: This morning we attempted to give recognition to our President-Elect, Dr. Newcomb (Sects. 8 and 18), but on account of rather small attendance we deferred his presence on the platform until this afternoon. Dr. Newcomb has a message to give to each delegate and I hope each delegate will carry that message back to his County Society. We are at a time when we need more and more activity in securing or defending certain legislation that is cropping up in our legislative halls.

Dr. Newcomb, having been in the Assembly for quite a number of years, is now well versed in all kinds of legislation, particularly that pertaining to medical legislation. So I will ask Dr. Newcomb to come to the platform and address you. Dr. Newcomb! (Applause.)

DR. NEWCOMB: Mr. Chairman and Members of The Medical Society of the State of New Jersey: I think most of you have been informed through our office of a lot of the medical legislation. I think you know of the Lien Bill, Senate 134, which was passed and signed by the Governor; Assembly 28, which was the professional boards Bill. That was signed by the Governor. Assembly 150, which was the chiropodist Bill—I understand that

there is a lot of opposition to that Bill now. That passed the Assembly some time in March.

Unfortunately, I was out of the Assembly for two or three weeks, but that would not have made any difference, but the Bill was passed at that time. As I understand it, there was not very much opposition to it, that the chiropodists were supposed to put in three or four amendments. With the other legislation, it was simply kind of overlooked and slipped through.

We have two Bills which are rather vicious Bills, perhaps. One is Senate 313. That passed the Senate on April 15th with a vote of 12 to 1. I did not have an opportunity to look up to see whose was the opposing vote.

Dr. Quigley: Senator Woburn.

Dr. Newcomb: That came over to the Assembly. The first I knew of it was last Monday a week ago. I was asked to suspend the rules and pass Senate 313, which I refused to do. I said I wanted to see the Bill, to have a chance to read it and see what action the Medical Society had taken. I was informed that the Morris County Medical Society was in favor of this Bill. I was handed six, eight or ten letters from prominent physicians in Morristown, endorsing this Bill and asking the Legislators to vote for it.

This Bill provides, or is mandatory, that the State Board of Medical Examiners admit a man for examination who hasn't even an M.D. degree, with no requirements for preliminary education.

The Bill is very short, and I am going to read it.

Dr. Newcomb read the Bill.

Dr. Newcomb: It was all new to me, but the Senator from Morris County was very anxious that the rules should be suspended and this Bill passed, which I would not allow. I wrote to the Medical College of Virginia, the School of Medicine, so-called, and asked for a report on this man, which I received by return mail.

It seems that it is the practice or was at that time in the Medical College, the School of Medicine of Virginia, to promote a man from one class to the other, whether he had conditions or not. This man had a condition in anatomy in his freshman year, anatomy in his sophomore year (I have his marks if you want them), inorganic chemistry in his freshman year, and inorganic chemistry in his sophomore year. He had four conditions, but they allowed him to go from the sophomore to the junior and in his junior year he made very fine marks.

He had one mark of 75 in his senior year. Other marks were 82, 94, 96, 92, 94, 77, 91, 95 and 90.

He is a very likeable chap, a fine personality, and I understand from the men of Morris County, a very able man. But it is a question for the Medical Society to determine—do we want to throw down all bars and admit a man to examination who hasn't a medical degree? In my eight years in the Assembly, I have stood for high standards. I do not see how I can get up or how I can sit still and let someone else get up and talk for this Bill that tears down our standards, because we will have no requirements, as I see it, for preliminary education. I cannot unless you direct me to, and I do not know whether I would do it then. I suppose I would. If the Medical Society do not want this Bill passed, I think now is the time for the Society to go on record against it.

I have several letters from doctors, pleading with us to pass this Bill, that this young man is a very deserving man. I feel very sorry for him. He came down to the Assembly last night with several of his colleagues and I told him that I could not support this Bill. He went on to talk and he questions whether he failed in these examinations or not. He asked me if I thought he failed.

I said, "What do I konw about it? I never even saw you or heard tell of you until yesterday. I don't know whether you failed or not. If you mean to insinuate that they failed you purposely, I do not know anything about it."

The Morris County Medical Society is on record against this Bill, but already a number of physicians from Morris County are on record for this Bill. Some of the Legislators were not in very good humor last night because this Bill could not come out and they wanted me to promise that I would not object to it coming on the floor for a vote, which I would not do. I would not make any promise at all, and the only thing that I did was to get the Bill referred to my committee.

It is in the Judiciary Committee. They cannot get it out of my committee without my signature unless they invoke the rule of fifteen signatures and then it must come up for vote on the floor to get it out of committee and then it must come up for a vote and get thirty-one votes.

I would like to have a free discussion on this Bill and know what you want me to do.

Dr. Arcangelo Liva (Hackensack): May I ask Dr. Newcomb if he knows the reason why he did not get his medical degree after putting in four years in medical college?

Dr. Newcomb: This is a letter from Dean Sutton: "In reply to your letter concerning Dr. Frank A. Wade, of Morristown, New Jer-

sey, I wish to state that he attended the Medical College of Virginia during the sessions beginning 1906 and ending in 1910. He did not graduate from our institution as he was unable to pass anatomy and chemistry. It seems that in those days students were promoted even though all subjects were not completed. This is the reason Dr. Wade was able to put in four years' attendance without receiving a degree."

The statement was made last night by one of the physicians from Morristown if we would pass this Bill and he would be admitted for an examination, that the college would give him his degree. I asked him if he knew that. He said he did not know it, but he thought they would, and if the Legislature would pass this Bill, he would take Dr. Wade and go down there and see if they would not give him a degree. I told him I would wire the Dean and ask him that, but I did not have a chance to do it last night.

You have heard the Bill read. It repeals all the other laws, "anything contrary notwithstanding." So, if you pass this, you have no requirements for your preliminary education and how many more men in the State of New Jersey haven't an M.D. degree?

Last year we had a Bill in the Legislature to admit a man to examination who never even had been in a medical college. He had just been associated with an M.D. for four or five years. If we are going to let down the bars in cases like this, what is going to happen to the medical profession?

Dr. Allman: Mr. President, I do not care why this man is not an M.D. It doesn't make much difference, I do not think. The fact remains he is not. Legislation of this type is certainly not conducive to holding up the standard where we hope to maintain it.

I, therefore, move that this House of Delegates go on record as being opposed to Senate 313, and that our Secretary be instructed to write to all the Assemblymen notifying them of that action by this body.

The motion was seconded.

Dr. I. F. Frost (Morristown): As a delegate and also as a member of the Executive Committee of Morris County, I want to say that the Executive Committee of Morris County is 100 per cent against this man's going through on this Bill 313. It is a long story. I am not going to take the time to tell the House of Delegates all about it.

Suffice it to say that the Executive Committee and myself did not know anything about this Bill officially until about, I think, three days ago. We were purposely kept in the dark about it. We heard about it unofficially, and I tried to find something about what was going on because of this subject. We knew something about it, and then we received word.

Dr. McMahon, the President of the Morris County Medical Society, wrote to Dr. Wilkes, and we received word of this thing. We immediately called an executive meeting and there was only one feeling about it—that this thing could not go on. We wired immediately to Dr. Wilkes and Dr. Ely that we were 100 per cent against this thing.

Dr. Wade, or Mr. Wade, as he should be called, has been associated with All Soul's Hospital, I think, for about fifteen years in the capacity of anesthetist. We have tried over and over again to help him get a degree. For some reason or other, he always felt there was something about it he could not get his degree.

Four years ago I was able to raise a fund for him so that he could go down and get the degree. I think he felt in his earlier two years he had trouble with one of the chemistry professors and with that he would not be able to go on and get the degree.

This was put through, I believe, through some political pull. I talked with Dr. Wade about it yesterday and he said that somebody had double-crossed him in Trenton. I do not know what he meant by that. It went through the Senate and Mr. King was very strong for the Bill, and, as you see, it went through the Senate very easily.

There have been a lot of men, friends of his, who have been very strong in trying to help him get this degree. I told Dr. Wade yesterday they put him on the spot as he had never been on the spot before. Where the men wished him well, I think they have made more trouble for him than he had before.

It has been a bone of contention with us, even with the hospital. I saw Dr. Martin two years ago when I was in Chicago, and Dr. Crowell. I talked it over with them, and Dr. Crowell said we would have to do something about it because Dr. Wade is an excellent man. He knows his work as well as any man in the hospital. As a matter of fact, I think he has taught most of the men their surgery.

He has been seen, when a man got into trouble (he was the anesthetist) to walk around, take the scalpel and finish the operation.

He is perfectly capable and I, for one, not in the way in which he is trying to get it, would like to see him get a degree. I think he is capable. I think he can do the work. He has had vast training and absorbs the knowledge very well. Around the hospital he is an anesthetist, a helper, adviser—something of a position I have never seen before and I have never known anything like it.

I am sure the men in Morris County would like to see him get a degree and be able to practice. If it goes on this way, it is very difficult for a man like that not to do a little practice.

He has been a great help to Dr. Mills and many others. Dr. Costello was very anxious to get his degree, and wrote a letter. Dr. Costello is a member of the Executive Committee. I told Dr. Costello I thought the way they had gone about it was wrong. Dr. Costello saw it immediately. He simply, in his enthusiasm, had tried to get this man through. When he realized what it meant, he turned around and I believe he telephoned Dr. Ely and told Dr. Ely he had switched his position and felt very strongly the way we did. I believe there is a means by which the State Society can grant a degree. Dr. Weigel showed me in the Journal of October there is a possibility in which a man can be examined or recommended and receive an M.D. degree. That is for the State Society to think about.

It is a problem. I don't know where it is going to end, but I want to register that the Morris County Medical Association, as a medical association, does not feel that this Bill 313 should go through at all. (Applause.)

DR. ALLMAN: I feel that should be incorporated in the motion, inasmuch as the Morris County Society is opposed to it that we go on record as opposed to it.

PRESIDENT ELY: Will you write the motion, Dr. Allman?

I recognize Dr. Satchwell, a member of the New Jersey Board of Medical Examiners.

DR. SATCHWELL: I want to apologize, Mr. President, for taking up the time of the Society in talking about this matter, the question of whether a man who does not meet any of the requirements of our Medical Practice Act should be given a license, but I would like to call your attention to certain things.

We are continually bombarded with requests from men from inferior schools for licensing in this state. We are turning them all down. They are awfully nice fellows, have mothers and wives to support and all the sob stories that go with those requests! We are trying to do our duty as it is written in the law and I think it is certainly a travesty on the situation to have to stand here and talk about the matter. The thing is based entirely on sentiment.

The man probably cannot pass the examinations of this day. He fulfills no requirements of the present Act and I would like to inquire from Dr. Frost whether he is an interne in All Souls' Hospital at the present time.

I feel very, very strongly that any attempt to do a thing like that is breaking down probably the most perfect practice act in the United States, an act which the lawyers write about as being an ideal act, a thing built up by experience in court decisions and we men on the Board of Examiners would certainly hate to be put in a position where somebody with a political pull can come along and get the Legislature to the point where they demand we give him a license. (Applause.)

DR. PETER E. MARAS (Jersey City): Mr. President and Members of the House of Delegates: I have just been warned not to make this too long. I will try to be to the point. It seems to me, as I gather it, that this man has had a worthy past and I know of similar experiences where men have attained unusual ability in surgery particularly, not exactly under similar circumstances. However, cases I have in mind were admitted before the Board, but one point I would like to call to your attention, gentlemen.

Did you ever have any difficulty yourself in getting before a Board or with a medical college or with any part of the practice, I should say, in gaining entrance to the practice of medicine? Those of you who have will appreciate what this gentleman's predicament is. I am not asking you to admit him to the examination. I do not know him. I just heard what was being said about him, but I have a picture in mind which I will never forget and which has compelled me to render my efforts to similar young men since my own personal experience.

My friends, just get this fixed definitely in your minds: We have the best Medical Practice Act in the Union, we are told. We wish to preserve that. We have to preserve it. If you realize what is looking the medical profession in the face in the very near future, you will then appreciate how necessary it is to not only preserve this present Medical Practice Act, but to even tighten it up because I know personally a number of loopholes that could be plugged up in that Act.

Secondly, I believe that after a man has honorably attained the position, and I assume that he did—as a matter of fact it was necessary that it was attained honorably,—the position that he holds today, and in view of the fact that the medical profession is so criticized today and will be criticized more in the near future because of the present tendency of the American medical colleges with reference to their present matriculations, it strikes me that it would be well for the medical profession to not merely turn this man away from its portals, but to look into the case with a little more

sincere interest, if you please, and get to the bottom.

And get this straight—by that I do not intend to bow a knee to a politician, because that, it appears to me, is where this gentleman's trouble began. The politicians are working on this case. The politicians are putting this case through. It would behoove us immediately to step into their path and say, "You cannot pass."

But let us be reasonable. There are other things we have to consider. Give him a chance, look into the case, let the medical profession be open, above board and fair and just, and see why he has not attained his degree. There may be a good reason for it. There may be some insignificant matters in previous cases and you must admit that it is a common practice, although they deny it.

As a matter of fact, just recently a statement was published that there is not a trade, there is not a profession, there is not a business that is more honorable, freer from polution, than politics. To that my answer is just this—that the American type of politics today is the curse upon America today, and I mean that.

With that point in view, remember it is the politician who has made the present medical predicament. I would suggest that this Society not merely go on record to investigate this, but instead to attempt to make some arrangement whereby a man who has attained that height of position may be by some manner of means left to the disposal of his profession, obtain his medical degree.

Calls for the question.

Dr. Morrison: Before this question is put, I believe our Constitution and By-Laws provide the solution for this case. This is not the first case of the kind that has come up. In the last ten years there have been five similar cases with which we have had to deal. We cannot permit our sympathies to allow us to lower our standards and the Constitution and By-Laws provide a solution.

Dr. Morrison read Chapter X of the By-Laws.

Dr. Ulmer: Mr. President and Members of the House of Delegates: One cannot help but applaud the candid exposition of this case by our colleague and able legislator, Dr. Newcomb. He has solicited the instructions of this House of Delegates to guide him in this vote. I interpret his unfortunate situation as either one of sympathy or one of preventing a hazardous precedent. Which way will this House of Delegates swing the pendulum?

Calls for the question.

President Ely: The motion presented by Dr. David B. Allman, of Atlantic City—in view of the fact that the Morris County Medical Society is opposed to Senate Bill 313, I move that this House of Delegates go on record as being opposed to this Bill and that the members of the Assembly of the State of New Jersey be individually notified of our action.

Dr. Frost: I should like to make a correction there. It is the Executive Committee. It did not come up before the Medical Society. We have not been able to call a meeting. It is the Executive Committee of the Morris County Medical Society.

President Ely: We will accept that change, Dr. Frost, the Executive Committee of the Morris County Medical Society.

The motion was seconded, was put to a vote, and was carried unanimously.

Dr. Satchwell: I did not have my answer from Dr. Frost as to whether he is an interne.

President Ely: Does he appear as an interne?

Dr. Frost: No, he is the anesthetist. I do not think he could qualify if the Bill went through because he is not a member of the medical staff. He is an anesthetist in the hospital. He was an interne for a period of about four or five years.

Dr. Satchwell: The present practice act exempts from the class of illegal practitioners men practicing in hospitals without a license who are members of the resident staff. This man is not a member of the resident staff. He is an illegal practitioner.

Dr. Newcomb: Mr. President, after listening to the gentleman from Jersey City, I am glad I am not a politician. (Laughter.)

Committee substitute for Assembly 238,—is Dr. Bien here?

Dr. Bien was not present.

36A. Osteopathic Surgical Bill

See Sect. 40

Dr. Newcomb: This Committee substitute is the so-called Osteopathic Surgical Bill. My information is that this Bill was drawn at a conference with the osteopaths and some medical men of Essex County. Is there anyone here who sat in at that conference?

Dr. Morrison: Yes.

Dr. Newcomb: Did you agree to it?

Dr. Morrison: I did not sit in the preliminary conference, but Dr. Satchwell was at the last conference. Dr. Areson, were you there?

Dr. William H. Areson (Montclair): Yes, sir.

Dr. Newcomb: Has the Medical Society of Essex County agreed to this Bill?

Dr. Areson: No, sir.

Dr. Newcomb: Did the Committee agree

to it, the Committee that sat in with the osteopaths?

DR. ARESON: Dr. Satchwell was the ranking member of that.

DR. NEWCOMB: Did they instruct Dr. Bien?

DR. SATCHWELL: No committee sat in. They had a Bill, which was 238, before your Assembly. A number of medical men were requested to sit with the Essex Assemblymen to discuss the question of what to do with Bill 238. The reason they asked us to sit in was because they had not received instructions from the medical men at that time as to what to do. By medical men I mean our Legislative Committee. They wanted to know what our attitude was.

In the course of the conversation we objected to this Bill 238 on the ground that it was a practice act in itself. It contained all provision of a practice act for osteopaths, including court orders, sections against advertising, illegal practitioner sections and so on. We said we objected to the Bill on that ground and also because it would automatically provide for a separate Board of Examiners.

I, individually, without any instructions from anybody or the County Society, suggested that the osteopaths had a right to introduce a Bill and I would suggest if they did introduce a Bill, they put it in as an amendment to the present Practice Act and drop 238. The County Society or any of its committees had nothing to do with it. It was an informal talk by some of the doctors including myself who were invited because, being a member of the Board of Examiners, I had some special knowledge,—the same type of conversation that takes place on the train when I come home from Trenton with the osteopathic member of the Board.

It was suggested that I sit with the osteopaths and help them draw up a Bill which would be an amendment to the present Practice Act. That was done. That Bill was not drawn up by the doctors or Essex County Medical Society. It was drawn up by two of the Assemblymen who were in sympathy with the osteopaths. The suggestions were made by me. The section relating to osteopathy in the Uniform Practice Act was taken out almost bodily and put into their section as a committee substitute.

That committee substitute, for your information, means that the osteopaths are willing to meet all requirements imposed upon them by our Medical Practice Act and take examinations the same as our doctors. In my opinion, the substitute is a good Bill, but I want you to get the right slant on it. It is not introduced by any of the doctors. If it is introduced, it will be introduced by the osteopaths as a substitute for 238, which they are willing to forego. It is an attempt on their part to come in through the same door that the regulars come in.

The Medical Society of Essex County has had nothing whatever to do with it. I have sat with them a number of times during the summer. I sat with these same osteopaths who were called into a meeting of the Uniform Practice Act of the State Society to discuss the Uniform Practice Act. Our attitude in Essex County is that 238 is not a good Bill and we have not instructed Dr. Bien to hold it in committee, but we do hope that he will, because we are against it.

Our attitude about the committee substitute is that it is a good bill after you see it, but the Essex County men individually or as a society should have no opinion on it until the State Society, through its Welfare Committee, has passed on it.

DR. NEWCOMB: I was asking for information. It was reported some of the Essex County men sat in with this Bill. It says, "Every applicant for admission to examination for license to practice medicine or surgery shall, in addition to the above requirements (this is the committee substitute) prove to the said Board he has received a diploma conferring the degree of Doctor of Medicine or degree of Doctor of Osteopathy, from some legally incorporated medical or professional college of the United States."

What are professional college men?

DR. SATCHWELL: Out of the Uniform Practice Act being drawn by the State Society. The word "professional" is put in to define what is medical. In other sections of this Bill you will find that a professional college means a college that teaches medicine in all its branches.

DR. NEWCOMB: This Bill is too long. I will just read some parts of it. It says, "Until November 1, 1941, any person licensed to practice osteopathy in this State and desiring to enter upon the practice of medicine and surgery, shall make application to said Board for license to do so. Applicants for examination shall present to the Secretary of said Board at least ten days before commencement examination, a written application on a form or forms provided by said Board and a fee of $25, together with satisfactory proofs, except as herein provided, that the applicant has served for a period of two years as an interne or resident surgeon in an osteopathic or medical hospital approved by said Board."

Are there enough osteopathic hospitals in

the State of New Jersey to have interneship?

DR. SATCHWELL: None in the State of New Jersey.

DR. NEWCOMB: How many osteopaths are in the state?

DR. SATCHWELL: About three hundred. There are sevent thousand in the United States.

DR. NEWCOMB: It would take a long time for three residents to serve in seven hospitals in the United States.

DR. SATCHWELL: There would not be many that would come in under that section.

DR. NEWCOMB: "Approval by the said Board or has completed a post-graduate course of two years in an approved school or college of osteopathy or medicine, provided any person duly registered or licensed to practice osteopathy in the State of New Jersey who presents satisfactory proof that he or she has served at least three years of practice in surgery in a hospital approved by the American Osteopathic Association or American Medical Association, shall be admitted by the Board to examination as to his or her qualifications for the practice of medicine and surgery without being required to prove that he or she has had two years' experience as an interne or has completed a two years' post-graduate course in surgery. Such examination shall consist of the subjects of materia medica and therapeutic surgery, and shall consist of the same questions as given to medical candidates."

Then they have added several other sections. It says in one section, "* * * or to those now practicing osteopathy under a valid license by virtue of the Act."

I was talking with Dr. McGuire about this Bill and he thinks this is a very vicious Bill. I am just asking, I am not giving my opinion of this Bill, but I am asking for instructions from the State Medical Society. It seems to me if we are going to have a Uniform Practice Act next year ,that is going to take in all the cults and probably do away with all these bickerings each year in the Legislature,—why pass something like this this year? Why not wait until a real Medical Practice Act comes in? I am just asking for instructions.

DR. QUIGLEY: Mr. President, I would like to say, isn't it a fact that over the signature of the Chairman of the Legislative Sub-Committee of the Welfare Committee, within the past week, a bulletin has been sent out to all key men and to the Presidents or Secretaries of the County Societies, stating that the Legislative Sub-Committee was opposed to the committee substitute? If that is so, I am afraid you are going to find it is going to put the Welfare Committee in rather a peculiar position.

DR. MCBRIDE: I move you, sir, the House of Delegates go on record as opposed to this committee substitute. There is no question in the world—I think we have had already too much discussion. There is no question as to what this committee should do. If we are going to do this, we will never get a unified practice act.

So I move you, sir, that this House of Delegates go on record as opposed to the committee substitute.

The motion was seconded.

PRESIDENT ELY: May I make this statement: The Executive Officers have taken strong action against the osteopathic Bill, have notified all the legislators of the position we take as a medical society, and when this substitute Bill came forward under the name of our Legislative Committee, we sent again a bulletin to every legislator, stating that we had a Medical Practice Act about ready to be introduced next year that would cover this very position, and that we were opposed to any substitute Bill.

Our key men have been well informed, have been requested to appeal to each legislator as to our opinion on this Bill.

I recognize Dr. Haggerty, the Chairman of the Legislative Committee.

DR. HAGGERTY: Mr. President, only last night in conference with the osteopathic chairman of the Legislative Committee, Dr. English said that I had all too much power in writing the letter that I did. He objected very much to my remarks which were, I understood, backed up by the Society.

PRESIDENT ELY: Yes.

DR. HAGGERTY: It is either a question of backing me up or letting me out.

PRESIDENT ELY: We are backing you up, Dr. Haggerty, because we knew the action of the State Society, knew the opinion of the Welfare Committee, knew the opinion of the Board of Trustees, and we are strongly opposed to any medical legislation that is being advanced by the osteopaths. We will oppose them strenuously.

Dr. Alexander is the Chairman of the Committee in arranging the Medical Practice Act which is now about completed to be presented before the Legislature next year.

DR. ALEXANDER: Mr. President and Delegates: While this committee substitute might have some good features incorporated in the Bill, my own personal opinion is that it has, I think it would be a mistake to pass that Bill

at this session. My own feeling is that it will make it just that much more difficult for our organization to get a Bill through.

Dr. Newcomb: Mr. President, I might say this Bill has not been reported out of committee. Dr. Bien said he would hold it in committee until next Monday night. He expected to be here this afternoon. I asked him to hold it until we could take it up in the State Society here today.

Dr. McGuire has just come into the room, and he has some very strong opinions on this, as he has on everything else. I would like to have his opinion on it.

President Ely: Dr. McGuire, would you care to address the house on the Osteopathic Bill?

Dr. McGuire: Mr. President, I just arrived.

President Ely: We have been looking for you all afternoon.

Dr. McGuire: I do not know what has been said or done. In reading over this Bill submitted to me, the committee substitute Bill, the first thing that I notice about it is the amendment of the Section 5 of the Medical Practice Act. There is a question as to whether it is constitutional to amend such paragraphs of the section. I would be somewhat in doubt of the legal question. I have asked one or two of my lawyer friends about it.

A man told me last night in order to amend an Act, the whole section of the Act should be included; that if this Bill as now drawn, Section 4, leaves out preliminary educational qualifications that each candidate must present to the Board to be qualified in taking an examination, that is, the high school qualification, one year interneship, one year per-medical and two years pre-medical after 1917, the question submitted was if this was omitted in the Act, whether it was constitutional.

I was informed that you cannot amend paragraphs of sections, but the section amended must be inserted at length. If the Bill is enacted, it would eliminate all subdivisions A and B of the present Act.

First, as I interpret the Bill, the new Section "F"—all licensed osteopaths, licensed by the Board, must qualify by taking a two-year interneship or residency in a hospital approved by the Board; second, a two-year post-graduate course in a hospital or college approved by the Board; third, a man must present credentials of having had three years' practice in a hospital approved by the American Osteopathic Association or the American Medical Association.

If they present such credentials to the Board, it qualifies them to take an examination, materia medica, therapeutics, and surgery. If they get a passing mark of 75 they shall be issued a license.

Section 5-A, which is a new section, is that other definition of osteopathy which broadens the definition of osteopathy in the present Osteopathic Act.

Section 9 is amended in this Bill. For instance, a man licensed in Pennsylvania wishes to come to New Jersey. He may do so provided he does not open an office. In other words, Section 9 of the Act is the exemptions of the present Medical Act. Commissioned officers of the army, navy and marines are exempt. We are unable to prosecute any of these officers while they are in service or not in service. They are qualified to practice.

Further in the Act, I don't quite get, in Section 9 whether it nullifies the requirements of these men to qualify to take the examination. I may be wrong in interpreting this, but I am interpreting that Section 9 will have nothing at all to do with the osteopaths, that we will be compelled by reason of the fact that the osteopaths under the amendment of the Osteopathic Act fulfilled all the requirements of the Act before the Board to be licensed as osteopaths. If I interpret it correctly, I would feel if an osteopath has been licensed from 1913 up to 1940, our Board would have to issue them a license because they have fulfilled all the requirements of the Board under the 1913 Act. I may be wrong.

Dr. Satchwell: You are.

Dr. McGuire: It says here certain provisions made for certain men to take the examination, qualifying for these three. I cannot figure it out how we could avoid giving a license to any osteopath who has met full requirements of the Board because Section 12 of the Act repeals the 1913 Act, except as set forth in paragraph 9. There is no Section 9 in the Osteopathic Act. I may be wrong.

President Ely: Dr. McGuire, won't we have to thrash that out by legal opinion? When two members of the Board of Medical Examiners do not understand the ruling. I think we will have to carry on the discussion at some other time.

Calls for the question.

Dr. Satchwell: Since I have been put on the spot, I am entitled to one word of defense before your question. First, I want to bring forward the fact that the Essex County Society or the doctors in that county had nothing to do with the writing of this Act. This was written by two members of the Assembly,

lawyers, whose names I can give you, for the osteopaths, for which they paid. Our persuasion was to drop 238, and if you come in at all to come in as an amendment to the present Act. If this Act is no good, blame the attorneys who wrote it. I didn't.

Calls for the question.

PRESIDENT ELY: There is a motion before the house. Dr. McBride, I think you made a motion. Would you please repeat the motion?

DR. MCBRIDE: My motion was that the House of Delegates go on record as being opposed to this committee substitute—and that was properly seconded.

PRESIDENT ELY: Dr. McBride made a motion that the House of Delegates go on record *opposing* this *substitute Bill presented by the osteopaths.*

The motion was put to a vote, and was carried.

DR. ARESON: May I ask what happens to the original Bill?

PRESIDENT ELY: It is still in committee and being held in committee by Dr. Bien and he will not let it out. This Bill was a slide-out with the idea of getting ahead of the original Bill.

DR. ARESON: I am Chairman of the Welfare Committee. We had a meeting last Sunday. In the first place, let me say that I had a meeting with the Essex Assemblymen and the Speaker of the House with my Welfare Committee, because I am convinced that our Assemblymen are against us. I think we are licked. So I forced a hearing with Speaker Clee and the Assemblymen. Dr. Morrison was there. The Speaker was most emphatic that this Bill come out of Committee. He said, "I made a very bad mistake in putting it in the hands of a committee, the Chairman of which was a physician. That was a mistake. It should come out of committee. It is not fair to the people."

The result of that conference was that Speaker Clee appointed a committee of Dr. Satchwell and myself, representing the medical profession, two of the osteopathic members present at the hearing, and three members of our Assembly. The result of that, in which I had some participation, not much, was the drawing up, revising of it by the osteopathic physicians. We had nothing to do with it and kept well out of it.

I speak because I feel sure 238 will be supported by our Assemblymen. I am sorry to say so. We have tried our best and, of course, will continue to bring pressure to bear upon it to see it our way. We are opposed to 238.

PRESIDENT ELY: We will inform them as to the action of the House today.

DR. MCBRIDE: May I make another motion, then? I move you, sir, that the House of Delegates go on record as being absolutely opposed to Assembly 238 in its present form together with the substitute and we notify by letter or telegram the members of the Essex County delegation, particularly, that The Medical Society of New Jersey is opposed to it.

DR. ARESON: An amendment that the Chairman of that committee be instructed to keep it in committee and not let it out.

DR. MCBRIDE: No, we are opposed to the Bill.

DR. ARESON: And the Chairman of that committee be instructed to keep it there.

DR. MCBRIDE: I accept that.

DR. JOHN F. CONDON (Newark): In addition to what Dr. Areson said, I would like to ask through the Chair what is the possibility of Dr. Bien holding that in Committee? It can be voted out and Mr. Clee warned us it might be. We are anxious and Dr. Bien is also anxious to keep it in committee. If it is voted out, I feel the Essex delegation is going to vote for 238.

DR. NEWCOMB: Mr. President, I would like to urge all members to get in touch with all Assemblymen forthwith, because there is a lot of sentiment for this Bill. I know a lot of the Essex men are going to vote for this Bill if it ever gets on the floor, and some Union men are going to vote for it, and some other men are going to vote for it.

If we can bring enough pressure to bear on Dr. Bien to hold it in committee, well, they can invoke the rule of fifteen, but then they have to get a majority to force it out of Dr. Bien's hands. There is a lot of sentiment for this Osteopathic Bill in the Assembly today and we are going to have a hard fight. Do not fail to get in touch with all your Assemblymen and bombard them with letters or telegrams, whatever you can do, and I will do my part to keep it in. I thank you. (Applause.)

DR. MORRISON: Mr. President, may I ask Dr. Areson a question? At the first conference we had with the delegation, didn't Mr. Clee promise us that no Bill would be passed this year creating an additional Board?

DR. ARESON: I don't know whether he promised that, but he said most emphatically he was opposed.

DR. MORRISON: Didn't he say they were also opposed to passing this Bill unless the medical and osteopathic professions were in accord on the Bill?

DR. ARESON: I don't remember.

Dr. Condon: Mr. Clee is accusing the State Medical Society and the Essex County Medical Society of gag rule on this Bill.

President Ely: There is a question before the house.

Dr. Areson: I want to say that No. 238 is vicious. The substitute Bill was not. You are going to elect that 238 Bill. That will win, I am sure of it.

Dr. McBride: You still have the Governor. Until he signs it, it won't win even if it passes the Legislature.

The motion was seconded.

President Ely: A motion has been made by Dr. McBride that the House of Delegates go on record opposing Senate Bill 238.

The motion was put to a vote, and was carried.

President Ely: We will see that the Legislators get a telegram direct from the Convention.

I may say I spoke to Dr. Newcomb about making a statement, but he has so many things on his mind. During the last several months we have received certain information that the doctors of our state society were not sufficiently active in letting the Legislators know just how we stood. The Executive Officers with the officers of the Society have kept well in line with all legislation and as soon as we knew of the possibility of any medical legislation that may come out on the floor, we immediately kept all the Legislators informed.

The Legislators tell us the osteopaths and chiropractors and chiropodists, with all their friends, immediately bombard them by mail or person and they do not hear a word directly from an individual physician. How true that may be, I cannot say, but I do know that our officers carry out the requests and the recommendations of our Legislative Committee.

It is one of two things: We as individual physicians have to play the same game with our legislators as the cultists do, get after them to let them know we are as much opposed as the cultists are in favor. They claim it is a demand by the public and that they are public representatives. If we just sit back, they are going to carry out what the public demands.

36B. Committee on Legislation

I recognize Dr. Haggerty. He has come in rather late on account of attending the funeral of Dr. Costill. I would like him to make the supplementary report of the Legislative Committee. Dr. Haggerty!

Dr. D. Leo Haggerty presented the supplementary report, as follows:

Action, Sect. 49.

To the Welfare Committee:

In my final report I want to emphasize the two important measures that we were able to have backed and made laws this year,—namely, S-134 (a compromise of last year's Physicians' Lien) which was mutually agreeable to the lawyers, insurance carriers and ourselves, and which became Chapter 146, Laws of 1935; also, A-28, which allows the professional boards to expend moneys collected by them and which became Chapter 121, Laws of 1935, after having been signed by the Governor. Assembly Bills 67, 68, and 69, in reference to examination of school teachers and school children, introduced by our President-Elect, Dr. Newcomb, have passed the House and now rest in committee in the Senate.

In the Bills that we have opposed, A-150, the Chiropodist Bill, passed the House and now rests in committee in the Senate, where we hope it will remain, unless properly amended to our satisfaction. A-110, the Beauticians' Bill, passed the Assembly after having been amended to our satisfaction and now rests in committee in the Senate, although it makes a profession out of a trade and still has dangerous features. A-238, the Osteopathic Bill, is the most vicious of all, still rests in committee in the Assembly, and although a committee substitute has been offered, it is still unsatisfactory and opposed.

I wish to call attention to S-313, designated to give a man a chance to take the State Board examinations, although he possesses no diploma from a medical school. This is legislation of the worst sort. How can we oppose low standards of the cults when our own profession endorses such legislation? We have no doubt that the man for whom this legislation was written is most capable, but the precedent is bad. This Bill has passed the Senate and now rests in committee.

We have had few meetings of the committee in Trenton this year, realizing the hardships to members traveling from all parts of the State, but most of our work has been satisfactorily accomplished through letters and, in urgent cases, by telegram. I wish to express appreciation for the hearty cooperation of members of the Legislative Committee.

An outstanding feature this year has been requests from legislators for information regarding bills with a medical bearing.

Dr. Wilkes has been active at all times and deserves much credit. Drs. Newcomb, Bien and McKinstry in the House, and Drs. Cole and Barber in the Senate have been a wonderful help in all medical legislation. The coöperation of Officers, Trustees and the Welfare Committee has been most gratifying.

D. Leo Haggerty, M.D., F.A.C.S.,
Chairman.

Dr. Haggerty: Last night's session was cut short due to the death of Dr. Barber and I think it is appropriate that a special committee should be drawn up to pass resolutions on his death.

I think at this time it is also appropriate to ask that all legislation be passed through the

Welfare Committee. I have been accused as Chairman of the Legislative Committee of having too much power, but it seems certain committees and certain members have gone out, and we meet this opposition every once in a while in the House.

Even last night there was a circular around that a certain committee of doctors who were supposed to be from Essex County had gotten together with the osteopaths and the committee substitute was endorsed by the State Medical Society. If such things as this are coming up, we are just going to have a hard time of it right along. Thank you.

PRESIDENT ELY: Thank you, Dr. Haggerty.

It is with regret that we hear of the death of Dr. Barber, one of our Legislators. I will appoint a committee on Resolutions, Delegates from Warren County, to draw up suitable resolutions.

DR. MORRISON: I do not see any man here from Warren County.

PRESIDENT ELY: I will appoint a committee later.

Sect. 43.

37. CONSTITUTION AND BY-LAWS—AMENDMENT

DR. CHARLES J. MURN (Paterson): I am Chairman of the Committee on Constitution and By-Laws. The report was read this morning. I simply want to read an amendment to the By-Laws that this committee has received from Dr. Quigley, as follows:

Dear Dr. Murn: April 20, 1935.

In conformity with Chapter XV of the By-Laws, I desire to notify the Committee on Constitution and By-Laws that I shall present the following amendments to the House of Delegates at the coming Annual Meeting:

"Strike out entire sub-section (b) of Section 2 Chapter V of the By-Laws.

(This sub-section relates to the method of nominating Fellows as candidates for election to the Board of Trustees, and reads as follows:

"(b) The Nominating Committee at the first election following the adoption of these By-Laws shall submit to the society the names of two Fellows, selected by the Fellows, as nominees for the Board of Trustees. As the terms of Fellows so nominated and elected Trustees expire, the Fellows shall propose their successors to the Nominating Committee; and the committee shall submit to the Society the names of the Fellows so proposed, as nominees for Trustees."—*Editorial Note.*)

"Amend sub-section (d) of the same section and chapter so that it shall read: 'Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.'

"Amend sub-sections (c), (d), (e), (f) so as to become sub-sections (b), (c), (d) and (e) respectively."

This proposal is my individual thought only and is prompted by these reasons:

When sub-section (b) of Section 2 Chapter V was adopted some six or seven years ago it represented a compromise of a by-law long in effect: That the Fellows constituted the Board of Trustees. In making provision for the Fellows to elect two of their number to the Trustees, it was done with the idea of placing upon the Board two members who were peculiarly experienced—having been ex-Presidents of the Society.

Experience has proved this provision to be unnecessary; the present Board of Trustees contains three ex-Presidents elected by the House of Delegates besides the two selected by the Fellows.

There is a feature to the selection of two ex-President by the Fellows, which, in my opinion, is not so good. If you will turn to Article VI of the Constitution you will notice that besides the six officers who are Trustees by virtue of their office, there are eleven *elected* Trustees and at least two must be from each of the five Judicial Districts. Consequently, when a term of one of the Trustees elected by the Fellows expires, they (the Fellows) are, perforce, limited in their selection—I should say entirely too limited—for the Fellow selected must come from that Judicial District that does not have at least two Trustees.

Then, too, the members of the Nominating Committee in that particular Judicial District may have an outstanding man whom they wish to propose for this position but are obliged to accept the *Fellows'* nominee.

If these proposed amendments commend themselves to your Committee, it might be well to have them placed before the House of Delegates by the Committee instead of myself.

Frederic J. Quigley.

DR. MURN: Dr. Quigley goes on to state his reasons for this amendment. I think if it is referred to the Reference Committee on Constitution and By-Laws, that will cover the subject, that it has been read in the House of Delegates.

See Sect. 54.

PRESIDENT ELY: We will refer that to Committee "B".

We will adjourn the House of Delegates to meet on Wednesday at noon to hear the Report of the Nominating Committee, and for the election of officers.

The meeting adjourned at 5:45 o'clock.

WEDNESDAY NOON SESSION, MAY 1, 1935

The meeting convened at 12:15 o'clock, President Ely presiding.

38. ELECTION OF OFFICERS

PRESIDENT ELY: The first order of business for the Third Session of the House of Delegates is to hear the Report of the Nominating Committee by Dr. Quigley.

Dr. Quigley presented the report of the Nominating Committee, as follows:

The Nominating Committee, all members being present except the representative from Warren County, met last night and made the following nominations which it respectfully presents to the House of Delegates:

President-Elect, Francis R. Haussling, Essex

First Vice-President, Spencer T. Snedecor, Bergen

Second Vice-President, William G. Herrman, Monmouth

Secretary, J. Bennett Morrison, Essex

Treasurer, Elias J. Marsh, Passaic

Trustees: James S. Green, Union; Blase Cole, Sussex; Herbert W. Nafey, Middlesex; R. M. A. Davis, Salem

Councilors: Second Judicial District, W. J. Sweeney, Hudson; Fifth Judicial District, Aldrich C. Crowe, Cape May

Delegates to the A. M. A.: Ephraim R. Mulford, Burlington; Blase Cole, Sussex.

Alternate Delegates: Hilton S. Read, Atlantic (to fill the unexpired term of Philip Marvel, resigned [Sect. 35]); Elmer Peter Weigel, Union; Samuel B. English, Hunterdon.

Standing Committees

Scientific Work: Robert S. Gamon, Camden.

Program and Arrangements: William J. Carrington, Atlantic; D. Ward Scanlan, Atlantic (to fill unexpired term of W. D. Olmstead).

Publication: Frank J. McLoughlin, Hudson.

Honorary Membership: Lancelot Ely, Somerset.

Hospital and Medical Education: Louis A. Pyle, Hudson.

FREDERIC J. QUIGLEY, M.D.,
Chairman.

PRESIDENT ELY: You have heard the Report of the Nominating Committee. We are open now to other nominations, first for President-Elect.

There was no response.

PRESIDENT ELY: For First Vice-President.

There was no response.

PRESIDENT ELY: For Second Vice-President.

There was no response.

PRESIDENT ELY: Do you wish to go down the line?

DR. ALEXANDER: If there is no objection, I move the nominations be closed.

The motion was seconded.

PRESIDENT ELY: I presume that will include the Secretary casting a ballot.

The motion was put to a vote, and was carried.

DR. LIPPINCOTT: I move that the ticket as read be elected.

The motion was seconded, was put to a vote and was carried.

PRESIDENT ELY: I declare the members on the ticket elected.

That being the only business at this session, we will close this session of the House of Delegates, to meet tomorrow afternoon.

The meeting adjourned at 12:25 o'clock.

THURSDAY AFTERNOON SESSION, MAY 2, 1935

The meeting convened at 2:10 o'clock, President Ely presiding.

Announcements by the President.

39. MEDICAL HISTORY CLUB

PRESIDENT ELY: I will officially discharge the Committee on the Robert McKean Medical History Club, with the thanks of the Board of Trustees and the President for the very efficient work it has done. Therefore, as a State Society, we have nothing to do with the publication of that history.

40. OSTEOPATHIC BILL

Sect. 36A, on p. 41.

We will take up at this time unfinished business. I think the most important unfinished business is in regard to the legislative problems that have arisen since we have been in convention.

At a meeting of the Welfare Committee called yesterday, certain actions were taken, and I am asking Dr. Lee, the Chairman of the Welfare Committee, to make the report. Dr. Lee.

DR. LEE: Mr. President and Gentlemen: As you all know, the special meeting of the Welfare Committee was called yesterday afternoon at three o'clock by the President, as he has stated, for the purpose of considering certain emergencies that have arisen in regard to the Osteopathic Bill, 238.

There were present at that meeting most of the members of the Welfare Committee, representatives of the Board of Trustees, Dr. Eagleton, and for part of the time, Dr. Quigley; also Dr. Newcomb and Dr. Bien, both members of the Assembly, and Mr. Goldburg and Mr. Paul, members of the Assembly from Essex County. There were also present two or three members of the Board of State Medical Examiners of New Jersey.

Ample time was given to everybody to say what they thought in regard to that matter; and as a result of this discussion, the motion that I am about to read was passed and ordered sent to the Board of Trustees and to this gathering:

"Dr. Frost moves that the Welfare Committee recommend to the Board of Trustees that the committee substitute for A-238, with modifications as presented today, be reconsidered by the House of Delegates and that this substitute Bill be submitted to an expert legal authority."

This was seconded by Dr. Satchwell and unanimously approved.

Mr. President, I would suggest Dr. Satchwell, having been so very thoroughly conversant with the development of these proposed Bills, that we ask him for further elucidation of this matter.

PRESIDENT ELY: Dr. Satchwell, will you address the House pertaining to this matter, please?

DR. SATCHWELL: Mr. President, the substitute for Assembly Bill 238, which was the Bill introduced by the osteopaths, came about as a result of a conference with some of the members of the Assembly from Essex County and a conference of several doctors was asked for by the members of the Assembly, who were anxious to learn the merits or demerits of Assembly Bill 238.

We told the Assemblymen that 238, the Osteopathic Bill, was a vicious Bill because, first, it was a complete practice act of their own with all the provisions in it which are in our Act. The clause relating to the rights of those now practicing osteopathy to practice under that new Bill was worded in such way that they would have powers to practice medicine in its fullest extent.

The Bill, being a practice act of their own, we felt it was the first step in asking for a separate board.

The fourth objection was that the practice of medicine and surgery in this state and all of its branches is controlled by the Medical Practice Act and that we felt that if the osteopaths wanted to practice medicine or to modify their present rights, they should do it through the existing legal channels, which was the Medical Practice Act.

Our objection was if they did not do it that way and had a practice act of their own, the medical profession had no control over osteopaths.

At that conference two osteopaths were called in, they having been in the other room at the beginning. I asked them, "Are you men willing to ask for what you want through an amendment to the present practice act?"

They said, "Yes."

"Are you willing to meet all conditions imposed upon you by the present practice act, educational requirements, examination the same as M.D.'s, interneship, supervision afterward by the Board of Medical Examiners?"

They said, "Yes."

The Assemblymen then asked us, "Why can't you compromise?"

They appointed a committee of two osteopaths, two doctors, and two Assemblymen. We drew up the substitute for Assembly Bill 238. That Bill provides, first, it is an amendment to the Medical Practice Act. The sections affecting the osteopaths are rewritten.

Section 4 in our Act sets forth all the educational requirements necessary before examination for license. That section is known as Section 4. In the committee substitute that is remodeled to state that after 1940 all those osteopaths wishing full rights to practice medicine and surgery shall have a four-year high school education, two years pre-medical, four years medical or four years in a school of osteopathy approved by the Medical Board, one year internship in a hospital approved by the Medical Board, and then examinations by the Board of Examiners, submitting to the same questions as the candidates for practice who have M.D.'s.

That Section 4 was left out of a copy that was introduced here the other day. That was the chief objection to that copy. Since the meeting two days ago that section has been put back. It was put back at our request by the two Assemblymen, who are attorneys and who were present here yesterday. It now makes that substitute as far as that section is concerned, the same as our Medcial Practice Act

in the educational requirements, interneship and examinations.

In the substitute, the men who graduate after 1940 come under the section I have just explained. The men who have matriculated at this time may take examinations to practice medicine and surgery, providing they fulfill the same requirements. That section is void after next year. That applies to present matriculants.

Those who are practicing osteopathy now are divided into two classes: Those who wish to have, in addition to the powers they have now, the right to practice medicine, shall have in addition to the requirements in the Osteopathic Act, two years in the medical college or two years in a college of osteopathy approved by us, one year interneship, and then take the examination with the doctrs at the regular state board meetings, in the additional subjects of materia medica, therapeutics and surgery.

Those who are practicing osteopathy now who do not want to or cannot go back to school for reëducation, for them we have remodeled the definition of osteopathy. Under their 1913 Act, osteopathy is defined in a few words as the treatment of disease by manipulation, the laying on of hands.

We have redefined that so that osteopathy now is defined as treating, prescribing, diagnosing, operating for any human disease, ailment, deformity, etc., except that they cannot use drugs for internal medication and they cannot do surgery requiring cutting.

Their old Act with the old definition is repealed. After 1940, all graduates of osteopathic colleges must submit to the same requirements as those with the degree of M.D. The Board is not enlarged. They have one member on the Board. That has not been increased. After graduation they are still subject to all the provisions of the Medical Practice Act. (Applause.)

President Ely: I would like to have Dr. Eagleton, the Chairman of the Board of Trustees, make a statement. Dr. Eagleton!

Dr. Eagleton: The matter was presented to the Board of Trustees this morning, and Dr. Satchwell made the report as he has made it here. It fulfills what we have been telling the osteopaths for years—if they will meet the requirements that the rest of us have had to meet, we haven't any objection to their coming along, practicing as we do.

As we see it today, this amendment will do that. It is to be submitted to the most eminent legal authority who is conversant with medical legislation, has been for many years, who had something to do with the framing of the original Medical Practice Act, the original amendment to the Medical Practice Act. If, in his judgment, this Bill is what it appears to be, the Board of Trustees are unanimous in recommending to you that opposition to this Bill be withdrawn.

Shall we endorse this measure? That is a thing that we are still not called upon to answer, but the Board of Trustees are unanimous in recommending to the House of Delegates that in view of the evidence that has been presented by this committee, that the House of Delegates should reconsider its motion of the day before yesterday in opposing the substitute for A-238, and the Board of Trustees recommend to you that this House of Delegates reconsider its action.

It is not a reversal at all because the action that you took on Tuesday was against an entirely different thing than is offered today.

I make such a motion, Mr. Chairman, that the House of Delegates, on the recommendation of the Board of Trustees, reconsider its action in opposition to substitute Bill A-238.

The motion was seconded.

President Ely: It has been moved and seconded that the Board of Trustees recommend to the House of Delegates that we reconsider the action taken on Tuesday on substitute Bill A-238.

The motion was put to a vote, and was carried.

Dr. Quigley: Just to get something before the House of Delegates, we move that, subject to the approval of the attorney to whom this Bill will be submitted, the substitute Bill A-238 receive the endorsement of The Medical Society of New Jersey.

The motion was seconded.

Dr. Newcomb: Mr. President, it seems to me it was brought up this morning that probably we should not endorse this Bill, that we should just be passive on the Bill. It does not seem to me that this is the thing to do. We have been talking for all these years, at least I have for eight years, saying that the minute the osteopaths came up to our requirements we would have no objection and would not oppose legislation.

If we are just going to be passive, the minute this Bill comes out on the floor, a number of the Assemblymen will come over to me and say, "Well, what do you say, Newcomb? What do you say?

I think we ought to pass Dr. Quigley's motion so that I can get up and say that the osteopaths have come up to our requirements the same as we have been talking all these

years, and that we are glad to endorse the Bill and go along with them. It will certainly give the Medical Society of the State of New Jersey a better standing with the public and with the Legislature, rather than if we are just passive.

They will say, "Now they have met your requirements, you haven't backbone enough to endorse it and go along with them." (Applause.)

DR. MORRISON: Mr. Chairman, this attitude outlined by our President is the attitude that I have advocated for a long time. We have established our standards and we expect that everybody asking for permission to practice the healing art shall come up to those standards. We have had opposition from the chiropractors, opposition from the other cults, but we have still maintained those standards.

Today here is a group of osteopaths who see the handwriting on the wall, that the whole medical profession in the United States is threatened with the imposition by the federal authorities of some system of socialized medicine and those osteopaths, seven thousand of them, want to receive the degree of M.D. so they may be employed if that comes about. In the other countries they are not employed; in Canada they are not employed. Here they would not be employed unless they were recognized as M.D.'s.

They have met our standards. Why not be magnanimous enough to admit them to our group? We will have to do it eventually.

Calls for the question.

PRESIDENT ELY: Dr. Quigley, would you repeat the motion?

DR. QUIGLEY: The motion, as I recall it, was that The Medical Society of New Jersey endorse committee substitute A-238, subject to approval of counsel to whom this Bill will be submitted.

PRESIDENT ELY: And referred back to the Welfare Committee for further consideration.

DR. QUIGLEY: Certainly.

The motion was put to a vote and was carried. (Applause.)

PRESIDENT ELY: We will proceed with the reports.

41. REGISTRATION AND ATTENDANCE

DR. MORRISON: Before we go to these reports, I would like to say a word. Last night we had registered here 179 Delegates and 238 extra physicians. Now here it is the last meeting of the House of Delegates to transact some of the most important business that is coming before us and we have forty-five members present, instead of 179 who were present, who would be here if the meeting had been held yesterday morning.

All the matters referred to the Reference Committees could have been acted upon last night or Tuesday night, and these matters could all have been brought back to us at a session of the House of Delegates Wednesday morning, and then we would have had a representative delegation.

DR. NEWCOMB: If you had had it yesterday morning, you would not have known anything about this Bill because we did not have these changes until yesterday afternoon.

PRESIDENT ELY: We would have to have conferences between meetings of the House of Delegates.

DR. MORRISON: My point is that forty-five men should not do the business of one hundred and seventy-nine.

PRESIDENT ELY: We had to have the Board of Trustees, Welfare Committee, conferences in the lobbies, conferences in the rooms of the men, before we could come to a solution. There has been a great deal of campaigning going on during the convention period. As I recall it, we had open opposition to this question the day before yesterday, and we have unanimous support of it today. That shows what time does.

Dr. Eagleton said the other night, "Let's sleep over it." That settles the problem. We get a new thought.

42. COMMITTEE ON CREDENTIALS

I am calling for the reports of the Reference Committees—first the Committee on Credentials. Dr. Morrison!

DR. MORRISON: There is no further report. As I said, we had 179 delegates registered, and a total registration of 852 with 415 physicians. *(Sect. 41.)*

Upon motion regularly made and seconded, it was voted to adopt the report.

43. REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

PRESIDENT ELY: The Report of the Committee on Resolutions and Memorials, Dr. Pollak, Chairman.

Dr. Pollak presented the prepared report, as follows:

REPORT OF COMMITTEE ON RESOLUTIONS

1. *C. J. Kipp Memorial Fund* (Sect. 12): Your Committee on Resolutions and Memorials to whom were referred resolutions presented at the first session of the House of Delegates begs leave to report that they concur in the resolution submitted

by the Section on Ophthalmology and Otology relative to the establishment of a fund to be known as the Charles J. Kipp Memorial Fund, and recommend that said fund be placed in the custody of the Treasurer as a separate fund to be dispensed with the consent of the Board of Trustees only on authorization of said Section when attested by the Chairman, Vice-Chairman and Secretary of said Section.

II. *Pure Food and Drugs Law* (Sect. 11): Your committee approves of the resolution dealing with the proper enforcement of the present Pure Food and Drug Law submitted by President Ely and the representative of the Union County Medical Society, and recommends that the various sections contained in said resolution be adopted, especially the emphatic provision contained in said resolution regarding the demand of a complete congressional investigation of the enforcement of the present Pure Food and Drug Law, and all other specific measures advocated in said resolution which is hereby annexed, and embraces in detail the various steps advocated.

III. *Col. Bigley and the E. R. A.* (Sect. 24): Your committee endorses the resolution recognizing the splendid service rendered by Colonel Bigley, of Elizabeth, in formulating and establishing under the E. R. A. the formula, technic, and machinery through which the medical profession of our State was enabled to participate in the benevolent relief work established under his leadership and subsequently so effectively carried out by Mr. Colt. It is hereby recommended that the appreciation of this service be attested by a fitting resolution to be signed by the President and Secretary of the New Jersey Medical Society. In this connection we recommend the adoption of a resolution by this Society expressing the Society's appreciation and its complete accord with the humanitarian and broad-minded concept so ably and so sensib'y set forth by the recently appointed Chairman of the Council of the E. R. A., Commissioner Chester I. Barnard.

IV. *Thanking Legislators.*—Your committee further recommends that the Executive Secretary be requested to formulate a suitable resolution of thanks to each member of the Assembly and Senate of New Jersey who was instrumental in supporting and placing on the statutes of the State laws tending to improve the various public health measures of the session about to come to a close, and likewise thank each member of the Legislature who has loyally supported the Legislative and Welfare Committees of our Society in the defeat of bills which were inimitable to the health and happiness of the people of our State, and have thus by their action upheld the dignity and honor of our profession. And be it further resolved that the President and Secretary of the Society affix their signatures thereto.

V. *Dr. Costill's Memorial* (Sect. 4): We further desire to supplement the sentiments expressed at the first session of the House of Delegates relative to the demise of our Past President, Dr. Henry B. Costill, who by reason of his ethical conduct, his untiring effort in the behalf of our profession, and by his leadership in our Society during a critical period demonstrated his loyalty to the high concepts of our profession and indelibly stamped himself as one entitled to the esteem and confidence of his fellow practitioners. His services within our ranks have redounded to the benefit of the profession; his lifeless body has now been interred, but his spirit and influences will continue to live among us.

VI. *Dr. Thomas Barber Memorial* (Sect. 36): We beg to submit as a memorial our appreciation of the services rendered by the late Dr. Thomas Barber, a practitioner of many years' standing and Senator of our State who gave of himself unstintingly, who by every act of his life and his long service to mankind demonstrated his adherence to high standards of our profession. His counsel and advice were ever at our disposal. His influence will be missed but his memory will e'er be dear to the practitioners—his fellows of the medical profession of our State.

VII. *Thanks to Committees on the Annual Meeting.*—Your committee hereby desires by resolution to express their appreciation and gratitude to all who assisted in making this, our 169th Session, a successful one, and while it is impossible to individualize, we extend our thanks to the Committee on Program and Arrangements, to the Committee on Scientific Program, to the officers and members of the Woman's Auxiliary, to the members of the Atlantic County Medical Society who have been our hosts, to the Atlantic City members, and to the management of this hotel who has maintained its high standard, as in the past, and has again demonstrated its courtesies and coöperative attitude which is hereby most generously acknowledged—all of which is most respectfully submitted.

Committee on Resolutions and Memorials

B. S. Pollak, Chairman,
Frederic J. Quigley,
A. D. Hutchinson,
E. H. Snavely,
W. B. Morris.

Upon motion made by Dr. Quigley, which was regularly seconded, it was voted to adopt the report.

PRESIDENT ELY: The Committee on Miscellaneous and New Business, Dr. Condon.

Dr. Condon was not present.

44. REFERENCE COMMITTEE "A"

PRESIDENT ELY: Report of Reference Committee "A"—Dr. Sprague.

Dr. Sprague presented the prepared report, as follows:

Reference Committee "A" has carefully reviewed the Report and Addresses of—

I. The President,
II. The Address of the President-Elect,
III. The Report of the Executive Secretary,
IV. The Report of the Secretary,
V. The Report of the Board of Trustees.

Herewith we present the following summary:

I. President's Report

Sect. 8, and Journal April, page 187

The President's Report covers work done and outlines plans of work to be done.

We approve the President's ideas of continuity of purpose from administration to administration.

Reading through the twenty-seven listed accomplishments of the year reveals the great effort put forth by the present administration. This report should be read by all.

Under Item 4. The Proposed Uniform Practice Act requires much examination and consideration. We wish to call attention to the fact that our present Medical Practice Act is very sound and one of the best.

Item 7. The action of the President in presenting the viewpoint of the State Medical Society to the President of the United States and other national officers who have to do with legislation or plans pertaining to medical care is endorsed by this committee.

Item 8. We commend the policy of the President in the creation of the several new and useful committees.

Item 10. We commend the further development of the Conference of the Allied Professions in the State and each county.

Item 17. The President's efforts to develop mutual understanding between the New Jersey Hospital Association, the Department of Institutions and Agencies, the Hospital Administrations and the physician are most commendable. We recommend that the project of the survey of the hospital should be eventually in the hands of the State Medical Society.

Under Item 19. We recommend publicity whenever possible on medical matters by organized medical societies.

Under Item 21. We wish to call your attention to the following quotation:

> "Unless the private physician shows greater initiative and an increased interest in this preschool age group, other organized community agencies will continue to wean away from him children whose parents would gladly pay for helpful service given by a competent doctor of their own choice."

We approve the fourteen recommednations of the President, all of which show the great need of further effort on the part of the physician.

We endorse the President's Recommendation No. 3, to separate the Committee on Hospitals from the Committee on Medical Education. (See p. 54.)

Recommendation No. 5. The President stresses the importance of the County Society in all medical matters. We agree with him that each County Society should have a properly functioning central office wherever possible.

Recommendation No. 11. Calls attention to the value of a Bulletin published by each County. This subject is a most important one and deserves the prominence the President has given to it.

All of the recommendations should have your interested attention.

We congratulate the President for his grasp of the needs of Organized Medicine in the State of New Jersey and we hope his report will stimulate renewed interest in the physician's welfare and the present status of organized medicine.

The President's Address

Journal May, page 303

The President's Address was a scholarly historical review of the evolution of medical practice and medical organization in New Jersey. He recalls that "service is the foundation of our profession".

He urges us to combat false advertising and misinformation.

He cites the great advances scientific medicine has made since the turn of the century and urges organized medicine to evolve solutions of its present economic problems.

II. The President-Elect's Address

Journal May, page 309

The President-Elect forcefully presented the message—that physicians must take a vital interest in politics and civic affairs.

He urged the further development of Allied Professional groups and their efforts put forth to send honest representatives to government positions and offices.

We regret that he has been forced by pressure of circumstance to tender his resignation as President of the Society. May he continue long in office of government. There we know he will carry on his honest and helpful work for the physicians and the people of New Jersey.

III. Executive Secretary's Report

Sect. 16, and Journal April, page 192

The Executive Secretary's report is complete, comprehensive and of great interest. We wish to call attention to the following important statement—"The outstanding need at this time is better organization and coöperation within the County Medical Societies."

All the topics touched upon are well covered. To quote again from this commendable report:

> "Mutual understanding and coördination of plans and efforts between the State Health Department and the State Medical Society are essential to the ultimate success of both these groups. The same may be said of the work of the members of allied medical professions and great start towards the latter has been made."

We would respectfully call the attention of the President and of the Board of Trustees to the increasing amount of clerical detail and committee meetings in the Executive Secretary's office. We recommend that from time to time the duties of the Executive Secretary be redefined. In that manner the main function and usefulness of the Executive Secretary will not be submerged in detail.

IV. Secretary's Report

Sect. 13, and Journal April, page 196

In the Secretary's Report we note with interest that the total membership of the Society has passed the three thousand mark.

We also note the statement that there is a persistent demand that the dues of the State Society be reduced.

This matter deserves attention. Physicians recognize the value of organized medicine. Medical organizations' affairs need to be administered. Proper administration requires to be financed.

Physicians must be willing to provide the means by paying sufficient dues. If we do not do so, we must take the consequences when other agencies take certain of our rightful activities away from us.

V. *Trustees' Report*

Sects. 9 and 10, and Journal April, page 197

We commend the good work done by the Board of Trustees and especially approve of the interest shown by the Trustees in their many meetings.

Their watchful guidance over the development of The Physicians' Lien Law has been most helpful. We commend the keeping of the Physicians' Lien distinct an dseparate from the hospital lien.

May we call attention to the fact that defects in any law may become evident after operation; and, therefore, we urge interested coöperation on the part of the individual physician and continued watchful supervision of the operation of the law by the State and County Medical Societies.

The Trustees rightfully stress the main object of the Society to be the "bringing back the leadership of The Medical Society of New Jersey for the protection of the political, economic and ethical interest of the licensed physicians of New Jersey".

Edward W. Sprague, Chairman,
M. F. Sewall,
Inglis F. Frost,
E. G. Herbener,
G. M. Knowles.

Dr. Pollak: I move the report of Reference Committee "A" be adopted.

The motion was seconded.

Dividing the Committee on Hospitals and Medical Education

Dr. Quigley: I want to discuss that report a bit. First, I would like to say with respect to the President, I hold Dr. Ely in the greatest respect and I think that he has made an outstanding President of this Society. Certainly, his record will compare favorably with any President who has preceded him.

I heartily concur in all the recommendations made, with the exception of one approved by the Reference Committee as to the separation of Hospitals and Medical Education into two committees. *(Jour., April, p. 191.)* Dr. Ely asked my opinion of this some time ago and I gave it to him. I am sorry I could not attend the Reference Committee meeting yesterday afternoon, because I was on a Reference Committee myself, and then attended the meeting of the Welfare Committee.

Of course, my own thought on this may not be correct, but I would like to give it to you. It seems to me this committee should be continued just as it is. Hospitals and Medical Education is a natural hook-up. It corresponds to the Committee of the A. M. A., Hospitals and Medical Education. It corresponds to a committee of the State Board of Medical Examiners, Hospitals and Medical Education. Of course, there are phases of this that are distinct from education, but a good part of the education is linked with hospitals. Certainly, the undergraduate and interneship, that is, medical education, and in the hospitals.

At the present time, our post-graduate education, for the most part as carried on by the State, has been in the form of didactic lectures, but there soon may be an extension of that so it may assume a more practical or critical course and be taken into the hospitals.

The committee undoubtedly was too small, but that was remedied easily enough by the request of the committee to enlarge it, which is allowable to any committee under the By-Laws. It functioned last year and this year under the very able chairmanship of Dr. Satchwell, who acted as the General Chairman and assumed the Chairmanship of the Sub-Committee on Medical Education, and Dr. Charles B. Kelly assumed the Chairmanship of the Sub-Committee on Hospitals.

Then there would be a general meeting twice a year so the two propositions, which I believe dovetail, were brought under the joint consideration of the committee. I have not heard yet any sound reason for the separation of these two committees.

President Ely: Dr. Quigley and the President disagree on his recommendation. I conferred with him before I made the recommendation, but in close contact or touch with this committee during the year we had certain problems. My first attention to the possible separation was called by the Chairman of this committee. Second, there was the amount of work that the committee had to do.

When it was found necessary to subdivide, it was difficult to get a physician who would assume the responsibility of the post-graduate course. The present Chairman of this committee felt he could not carry on because the burden was too great. So, through the recommendation or knowledge of the Board of Trustees, we made a tentative change.

I may mention names. Dr. Renner assumed charge, but immediately said, "I am a state officer. I cannot be connected with any hospital movement. I will gladly take charge of the post-graduate work, but I cannot take charge of any hospital situation."

That again opened up a situation and in conference with the former Chairman, he has agreed to assume the responsibility, but still felt that the work was so large that it should be divided. I had Dr. Satchwell appear before

the Board of Trustees to make his explanation and the Board of Trustees seemed to think well of it, as I understand it. Dr. Satchwell is well acquainted with the situation. He knows the increasing work that is going to be placed on the Hospital Committee. It will increase with the recommendation made to the House of Delegates. He also knows the increased amount of work that is the part of the post-graduate course and that is the reason I thought it would be well to separate these two committees.

I am going to ask Dr. Satchwell to make his remarks that he made before the Board of Trustees. Dr. Satchwell!

DR. SATCHWELL: In the first place, on paper the two committees are related. The Hospital Committee probably does have something to do with internes in hospitals which is really the fifth year of medical education. But from a practical standpoint they are two committees, two subcommittees that are not related at all.

We have had no meetings this year because the year before we could not get a quorum. We did have meetings and operated without a quorum. As soon as a meeting is called, the one group who feel they are assigned to hospital subjects want to know what it is going to be about. "Is it about post-graduate education? Then I won't be there."

It does not work well in having meetings. Then, again, I do not think the plan of the A. M. A. or State Examiners, because they have such a joint committee, should control us. I think it should be controlled entirely by our own problem. We have had a five years' look at this, the post-graduate education is building up.

It is true that we have reached saturation, probably, in didactic lectures, but we are just beginning in clinical teaching and it is our aim to put clinical teaching in the hospitals of this state. We know very definitely one university is about to tie up with a hospital in the upper half of the state, which is now of teaching grade.

The work is going to be tremendous. One item is thirty-two conferences (I have kept pretty good track of what I have had to do for this report), with universities in New York and Philadelphia, each one taking a half day. To that is added the tremendous burden of lining up anything between sixty and a hundred lectures and dovetailing them in at a certain time of year.

The work is bigger. In about another year, I feel sure the State Society will have to carry it itself, which I think, is as it should be. We are not a money maker for a university and an extension division of any university, as I know, being an officer of one, is looked upon as a money maker. They are not making money on us and it has been suggested to me this year tha twe disconnect ourselves from them.

It has been a fine thing up to date to be associated with a university of age and dignity, but I find that is no longer necessary. My introduction as a representative of the State Society will carry me a lot further than introducing myself as a technical adviser of Rutgers University.

It is my ambition to run this committee as a department of education through the office at Trenton. It will have to be done if the work is continued because we will have the entire clerical situation on our hands. That can be done, by the way, very easily at no expense to the State Society. The income from the work has always supported this activity and will easily do so in the future.

It is my ambition to get my personality out of this thing. The contacts are personal contacts. For two years we have had no man, no matter how big he is in any university, refuse to lecture for us. That is a personal contact which will disappear with me if I step out. I am not conceited enough to tell you the post-graduate work will stop if I step out, but it will be very much inactive until the next man has built it up.

I feel if this is run as a Department of Education for the State Society, the State Society will be in front, and not me. That is my big reason for asking for a disconnection of it. If the Hospital Committee has anything to do with education, it can easily be carried on by contact with the other committee. My personal experience through contact for five years leads to the recommendation that the one committee be divided into two.

DR. SPENCER T. SNEDECOR: I would like to express my own opinion on this subject, for the reason that I anticipate a year or two in advance, possibly. I think the two committees should be separated, as President Ely has recommended, and Dr. Satchwell. They are two different subjects.

Post-graduate teaching can be carried on, is big enough for one committee to do, but that is not the crux of the problem. The thing that is facing us in the next two or three years is the Hospital Committee. Nobody has particularly gotten into that subject yet.

I am very happy that Commissioner Ellis is with us this afternoon. I can mention the subject in his presence because I know of no greater problem facing us in an economic way,

a scientific way, than closer coöperation, interrelation between this profession and the hospitals in the next few years.

We need a separate committee—one of the most important committees in this Society, the Hospitals Committee—to get into the hospital problems and work on them. (Applause.)

Dr. Arcangelo Liva (Hackensack): Having been a member of the Education and Hospital Committee of the State Society for several years and, fortunately, the Chairman of the Educational Committee of the State Board since 1931, I am very much in accord with Dr. Quigley's idea because last year the State Board of Medical Examiners saw fit to combine the Educational Committee, of which I was Chairman, with the Hospitals Committee. Therefore, the two committees are combined now in one under my Chairmanship.

Dr. Satchwell happens to work with me in that committee, while I am under his chairmanship in the State Committee. I do not see, really, any necessity, any plausible reason for the separation of the two, because the subjects or matters which come under the consideration of these two committees are absolutely dovetailing one another, and I can see no reason for separating medical education from hospital supervision, because as a matter of fact, the inquiries should come here. Examining candidates for licensure is considered medical education. That I consider one of the most important reasons why these two committees should be continued as one.

As far as having meetings, I do not know that we had any difficulty in the previous years. Dr. Kelly, as Chairman of the subcommittee, called three distinct meetings, I believe, which were attended by Dr. Snavely and Dr. Weigel, of Plainfield, and someone else. We had no difficulty in carrying on the work of these two committees combined. If we come to clinical teaching as post-graduate teaching in the hospitals, what is teaching, if not medical education?

Dr. Morrison: Mr. Chairman, I think we all recognize the enormous amount of work that has been done by this committee under the chairmanship of Dr. Satchwell. When Dr. Satchwell comes to us and requests division of this committee, I believe the House should support him.

Dr. Quigley: May I say just one more word? Of course, this difference of opinion, to me, is stimulating and I recognize that there is that point of view and there is some argument for it. From the standpoint of organization, with the extension of the work we are setting up an enormous number of separate committees. It was not so long ago we had that difficulty and when the By-Laws were rewritten the atempt was made to consolidate some of those committees which were related, and then divide them up into subcommittees.

To illustrate: The Welfare Committee is concerned with a large number of problems. It has legislation. It has at the present time a new subcommittee on Medical Practice. We all appreciate, I am sure, the enormous amount of work that subcommittee has done. We have had the Committee on Uniform Medical Practice Act. We have had all these separate committes, subcommittees working and yet it has been unified under the Welfare Committee.

In addition to that, the Welfare Committee is supposed to be charged in the By-Laws with public health. We have had Dr. Nichols as a member of the Welfare Committee, but continued the Public Health as a special committee so that work could stand out during its development.

Now we are setting up and have set up quite a number of other committees that have to do with public health. You have Maternal Welfare, you have the new Committee on Cancer; and they may develop and want a policy which is at variance with the principles in some other direction.

One of the things we have to do soon, in my judgment, is to tie all these committees under the Public Health Committee and possibly separate it from the Welfare Committee. So far as this committee is concerned, there isn't any doubt at all of what Dr. Snedecor said about the importance and necessity of intensive work on hospitals. But that is no reason, it seems to me, for separating these two. They go together.

If and when we are able to effect better standardization so far as our control is concerned and the advancement of the post-graduate medical education, so it is more clinical, it is all the more reason why this committee should stay as it is.

It is true, as Dr. Satchwell says, that there is no particular reason why we have to be governed by what the State Board of Medical Examiners has done, but it is well to consider they must have had some good reason for joining what used to be separate committees into one. While I am not a critic of the A. M. A., I do think there must be a sound reason for the establishment of that committee as one. So I would urge you to consider it from this standpoint—do not be getting too many separate committees. If you have a subject that hangs together, it is much better, it seems to me, to get a good-sized committee,

with two good subchairmen, and to work out the problems under one committee chairman.

PRESIDENT ELY: Dr. Renner, you were serving on this committee. Would you mind making a statement?

DR. QUIGLEY: I should like to move, Mr. Chairman, the recommendation that the Committee remain as it is. I move an amendment.

DR. RENNER: There is nothing further to be said on the question. It is just one of those hard questions, a matter of opinion of the members of the Society, whether they want to split it up or keep it in one committee with two separate chairmen. It is a positive fact that one man cannot do all the work. He has to have assistance. It does not really make any material difference which way it is divided up.

DR. SATCHWELL: Just one more word. Dr. Liva's committee is different from mine. Mine has real, honest-to-God work to do. Dr. Liva's work is small. It isn't anything compared to what it is going to be when Stanley Nichols and I have to hook up and put through a program of health education. Dr. Nichols has a plan which he cannot offer to you now because it isn't ripe. I can tell you, of course, it is possible to run that committee with two subcommittees and I can also promise you the work won't be done if that is left as is.

It simmers into a proposition like buying a hat. You can take a green one or a brown one. You can have one committee with two subchairmen or you can split it. From the standpoint of ease of work, it is my opinion it should be split.

PRESIDENT ELY: I think those who have been in this work should understand the large problems they have to deal with. As it may be, the Hospital Committee will have a greater amount of work to do in the next few years. If it undertakes to do the work that is proposed, it will have its hands full.

I still feel for the welfare of our State Society, for the welfare of the hospital situation, for the welfare of the post-graduate course, they can work far better separately than they can under one committee with subcommittees. The subcommittee proposition is a very good one, but sometimes the subcommittees do not know just what their functions are. When they have a definite duty to perform as a separate committee, they know what their functions are; and I still feel that for the welfare of both the post-graduate and the hospital situation, they should be divided.

There is a motion before the house and it has been seconded.

DR. MORRISON: There is an amendment before the house. Has that been seconded?

PRESIDENT ELY: The motion is that the recommendation of Reference Committee "A" be adopted.

DR. EAGLETON: May I ask Dr. Sprague to read again that portion of his report so that the Society will have a little emphasis? He recommends that every now and then the duties of the central office shall be reëxamined. Would you read that part again?

DR. SPRAGUE: Dr. Eagleton, I think you perhaps misunderstood me. The duties of the Executive Secretary ——

DR. EAGLETON: That is what I mean. Would you read the wording of it again?

DR. SPRAGUE: "We would respectfully call the attention of the President and of the Board of Trustees to the increasing amount of clerical detail and committee meetings in the Executive Secretary's office. We recommend that from time to time the duties of the Executive Secretary be redefined. In that manner the main function and usefulness of the Executive Secretary will not be submerged in detail."

DR. EAGLETON: I asked Dr. Sprague to reread this because those of us on the Board who are rather close to the operating are apt to lose the big ideas on account of our closeness to them. That, to my mind, is one of the most important things that Dr. Sprague has said.

I move that that part of the recommendation be referred directly to the Board of Trustees for their attention, that their attention be called to the fact that we should look every now and the nover our machinery and see if we should not readjust it.

DR. POLLAK: There is a motion before the house.

PRESIDENT ELY: With a suggestion of amendment.

Dr. Quigley, will you repeat your amendment?

DR. QUIGLEY: My amendment is that the recommendation of the Reference Committee, so far as the separation of the one committee into two, be not concurred in.

PRESIDENT ELY: You have heard the amendment made by Dr. Quigley. All in favor of this amendment, will please say "aye"; those opposed, "no".

I think the noes have it. The motion is lost.

We will act on the original motion, the adoption of the report of Reference Committee "A". Dr. Eagleton made a recommendation only.

The motion to adopt the Report of Reference Committee "A" was put to a vote, and was carried.

DR. EAGLETON: Now I move, Mr. Chairman, that that portion of the report that Dr. Sprague has made be referred directly to the Board of Trustees to call their attention to a thing that has been seen by the Reference Committee and that has perhaps been overlooked by the Board of Trustees themselves.

I make that in the form of a motion to go directly from this House of Delegates to the Board of Trustees.

The motion was seconded, was put to a vote and was carried.

45. REFERENCE COMMITTEE "B"

PRESIDENT ELY: We will hear the Report of the Reference Committee "B", Dr. Ulmer, Chairman.

Dr. Ulmer presented the prepared report, as follows:

REPORT OF REFERENCE COMMITTEE "B"

To the President and Assembled Delegates of The Medical Society of New Jersey:

Herewith, follows report of Reference Committee "B" appointed by the President, on committee reports assigned for its consideration, namely:

I. Report of the Committee on Constitution and By-Laws
II. Report of the Insurance Committee
III. Report of the Committee on the Physicians' Lien Law
IV. Report of the Publication Committee
V. Report of the Finance and Budget Committee
VI. Report of the Treasurer

I. Report of the Committee on Constitution and By-Laws

Journal, April, page 202

No suggestions to make other than this minor one—we note that it is suggested in the Committee's Report that a copy of the Constitution and By-Laws be sent to the President and Secretary of each component County Society. We feel that this dual mailing is unnecessary and would respectfully suggest that a copy be sent only to the Secretary. It is obvious to all that the President of our County Societies change, in most instances, yearly, while that of Secretary is changed less frequently. The Secretary is and should be the custodian of all such books and records.

II. Report of the Insurance Committee

Sect. 19, and Journal, April, page 222

We approve of the report of this committee and urge our physicians to consider favorably placing their insurances through the State Medical Society. This Committee on Insurance has a splendid service to offer to each member of each component County Medical Society, at a considerable saving. Reference Committee "B" would recommend that periodically, at least once a year, a circular letter be mailed over the committee's signatures, to each member of the State Medical Society. This letter could well explain the several insurance plans offered by the State Medical Society and the definite advantages that accrue to our members.

We understand that mailings are occasionally made by the insurance agents to the members, but it is the opinion of the members of Reference Committee "B" that an informative letter issued periodically by the Committee on Insurance would be more effective in its purpose.

III. Report of the Committee on the Physicians' Lien Law

Sect. 20, and Journal, April, page 209

We commend this committee for its active and effective work. It has had a big job this year and has done it well, the preparation of a new Physicians' Lien Bill. This new Bill, now a law, does not include a fee schedule and we, the members of Reference Committee "B", believe it to be a more satisfactory and workable agreement for protecting the physician against loss than the old one which was really an amendment to the Hospital Lien Bill. (Sect. 51.)

IV. Report of the Publication Committee

Sect. 14, and Journal, April, page 200

This committee's splendid work and very comprehensive report has been considered with a great deal of interest by the members of Reference Committee "B". We join with all the other members of our State Medical Society in congratulating both the Publication Committee and the Editor, Dr. Frank Overton, for their fine product, The Journal, which certainly compares favorably with similar publications of other State Societies.

However, our Committee on Reference will assume its privilege and will respectfully suggest several changes in the preparation of The Journal, which, we believe, will make it an even better and more attractive periodical.

First—We would suggest that all advertising matter be deleted from the front cover. This most prominent page of our publication could be made more attractive, we think, by having printed thereon only the caption, the index of contents and probably the Society's recently improved seal. We are not unmindful of the fact that there will be some slight monetary loss sustained by relocating the present advertising set-up on another less conspicuous page, yet we feel that there will be a greater gain in a more attractive cover.

Second—We would suggest that the pages which recite the names of the officers and many committees of the State Medical Society be moved from the rear of The Journal where they now appear and be placed in the front.

Third—Your Reference Committee "B" would respectfully suggest to the Publication Committee that a dignified standard of advertisements in our Journal should at all times be maintained. It is our thought and recommendation that only those advertisements that purvey merchandise or service related to medicine or allied professions should be acceptable to the Committee on Publication. It is neither the province nor the intention of your Reference Committee "B" to be too critical, but, in a

purely constructive way, we question the advisability of the Publication Committee accepting, in the future, any advertisements from tobacco companies who make extravagant and dishonest claims for their products. It must be remembered that there are, no doubt, many members of our State Medical Society who frequently advise their patients on the non-use of tobacco and therefore the advertising display that appears so prominently on the back of recent issues of our Journal places these colleagues in an embarrassing position. The Publication Committee states in its report that its "financial condition is excellent". By all means then, let our Journal pioneer if it must, in a program of ethical advertising for an ethical profession. Suffice for your committee's suggestions to the Publication Committee concerning the Journal.

We note in its report that the Publication Committee desires that it be authorized by the House of Delegates to edit remarks that are made by speakers before the House. We quite agree that occasionally remarks are made entirely impromtu and without complete verification of facts and opinions. We, therefore, recommend that the Publication Committee be privileged and authorized to return any article to the speaker and ask him to check and re-write it, if, in its opinion, the article contains extravagant and inaccurate statements. This action will insure correct and dignified records for the Official Transactions of the House of Delegates.

Your Reference Committee "B" heartily endorses the desire of the Publication Committee that the House of Delegates approve its plan for the conduction of a Book Review Department in the Journal. We believe this new Department will be a popular one.

See Sect. 46A, p. 60.

V. Report of the Finance and Budget Committee
Sect. 17, and Journal, April, page 199

This report concerned chiefly the question of the amount of annual dues to our State Society and it was to this quesiton that your Committee "B" gave a great deal of thought and discussion. Your Committee was furnished with many disagreeing opinions on this subject of annual dues prior to its meeting on Tuesday evening and since then, and we trust that we have considered every argument fairly.

As the committee spokesman, I am happy to report that your Reference Committee "B" is in entire accord in its opinion and that opinion is that there be no reduction in the State Society's dues this year, and that they remain the same as last year, namely, $13.00 per capita.

We make this recommendation because, to us, it seems desirable that the scope of activities of the State Medical Society should be increased rather than curtailed, and too because we believe that contingencies are pending in social and economic legislation that suddenly may become acute and require outlays of the Society's funds.

VI. The Treasurer's Report
Sect. 15, and Journal, April, page 199

We approve of his report and have no suggestions to make. His analysis of the assessment, showing each member where his $13.00 goes, was both interesting and informative.

Chester I. Ulmer, Chairman,
Thomas B. Lee,
Frank W. Pinneo,
Frederick P. Wilbur,
A. H. Coleman.

DR. MORRISON: I move its adoption.

The motion was seconded and was adopted.

46. By-Laws Amendment

DR. QUIGLEY: Mr. President, may I ask whether the Committee on Constitution and By-Laws received an amendment which I proposed, which was submitted, I understand, under New Business the latter part of Tuesday afternoon, by the Chairman of the Committee on Constitution and By-Laws, Dr. Murn?

PRESIDENT ELY: I remember Dr. Murn presented such a change, but whether it got into the hands of the committee I am not certain.

DR. QUIGLEY: The point I want to make is whether it has been submitted.

PRESIDENT ELY: Dr. Pollak, did you receive such an amendment from Dr. Murn?

DR. POLLAK: No, I did not.

DR. QUIGLEY: Mr. President, it would seem to me that perhaps this might be the time to again read that change, because it must receive two readings.

DR. MORRISON: Have Dr. Quigley present it again.

DR. QUIGLEY: The amendment received first reading on Tuesday. The amendment that I proposed was to Chapter V, Section 2-"b", to delete the paragraph which reads as follows:

Dr. Quigley read the paragraph beginning with "The Nominating Committee at the first election following adoption of these By-Laws", and ending with "* * * to the Board of Trustees."

DR. QUIGLEY: The amendment which I propose is—"Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees."

The reason for this proposal, Mr. President, is this: When these By-Laws were revised completely in 1929, this Section "b", which allows the Fellows to select two Trustees and then propose their names to the Nominating Committee, was in effect a sort of compromise because formerly all the Fellows were members of the Board of Trustees.

There was an additional reason. The feeling was that it was highly desirable to keep on the Board of Trustees a couple of men who

had gone through the chair and were familiar with the procedure and policies of the Society. Now experience has proven that that is unnecessary because since this change was effected, at least two or three Fellows have been selected as members of the Board of Trustees by the Nominating Committee and the House of Delegates independently of the fact that they were proposed as Fellows.

We will take, for instance, Dr. McBride, Dr. Eagleton and myself. We are not the selection of the Fellows. We are the selection of the Nominating Committee in the House of Delegates. So it is unnecessary.

The second objection to the continuance of this is as follows: As the successors of the Fellows, as the terms of the Fellows so selected expire, it is necessary for the Fellows to select their successors. They must also fit into that councilor district in which they reside, because under the Constitution at least two Trustees shall come from each councilor district.

It limits the selection of that Trustee to a very few and it prevents the Nominating Committe from selecting a Trustee whom they might wish. So I propose that amendment merely to conform to that.

I move the adoption of these amendments.

PRESIDENT ELY: We will consider the first motion first. This would really come under recommendations of the Committee on Constitution and By-Laws, Dr. Quigley.

DR. MORRISON: It was not reported under this committee, so it comes up under New Business.

PRESIDENT ELY: However, we are taking up reports of Reference Committees. That can come up under New Business. It was not considered by the Constitution and By-Laws Committee. We will bring it up under New Business.

QUESTION: Couldn't we act on it now?

PRESIDENT ELY: We are out of order. I would like to get on with the Reports of the Reference Committees. We have a motion before the House, and I think that had better come up under the proper channel. (Sect. 54.)

46A. PUBLICATION COMMITTEE

(Continued from Sect. 45 IV, p. 59.)

DR. BARKHORN: I want to talk on the motion to accept the Report of Reference Committee "B". I would urge earnest consideration of the words, "tobacco manufacturers", and what follows. The Publication Committee does censor the ads. The Publication Committee chose Chesterfield instead of another which was also offered, because they do not have objectionable ads. This ad appears in at least twenty state journals. It would mean monetary loss equivalent to the dues of fifty members to take the ad from the Journal. It would mean a monetary loss equivalent to the dues of twenty-five members to put it inside the Journal instead of on the cover.

The same thing applies to the front page. It means a monetary loss of the equivalent of twelve and one-half members to put it inside instead of on the cover. I particularly urge attention to "tobacco manufacturers" and what follows, as it means a loss of between $500 and $600. We chose it because it was not an objectionable ad.

DR. MARSH: May I say a word with regard to this report of the Publication Committee? There was mention by the Reference Committee also of the question of editing the Transactions. This is a matter about which I spoke to Dr. Barkhorn last night, and I think he is in agreement.

"The committee, therefore, recommends the House take the following action: Resolved, That the House of Delegates authorize the Publication Committee to edit remarks made during debates, but always with the consent of the speakers and of the House."

It seems to me, perhaps I am wrong, that that is a little bit loose in the wording, in that it opens the possibility of editing by the Publication Committee of remarks made to the House, which might perhaps be a criticism of the committee or administration or officers or somebody else in debate which they might wish to change. It says, "* * * with the consent of the speakers * * *"

That is true, and Dr. Barkhorn tells me that was all intended. It would seem to me in these days when free speech and free press are more or less endangered, anyway, in the country, possibly he would accept as a safeguard for the future a change in the wording something to this effect: "* * * but always with the approval of the speakers as well as of the officers of the House."

If it were put that way, I think it would safeguard against any possibility of a speaker having something he said perhaps changed in some future time by some other committee in a way that perhaps would spoil the gist of his remarks.

DR. BARKHORN: That is perfectly acceptable to the Publication Committee. Of course, the idea was really the converse of what Dr. Marsh says. A man wanted to change his statements, but in view of the fact that he had publicly made them, he did not feel that he could change them. This gives him an opportunity to do so. That is perfectly all right.

DR. MARSH: A man should be assured the right to have his own views represented, regardless of whether they meet with approval.

DR. MORRISON: Why not allow this to go with the approval of the speaker? The Chairman of the Publication Committee sends to the speaker anything that is objectionable and asks him to revise it. Why have the extra delay of waiting for confirmation by the officers of the House?

DR. MARSH: But let us be sure of it.

DR. BARKHORN: That is perfectly acceptable.

PRESIDENT ELY: I approve somewhat recommendations of Committee "B". During the conference, I attended the meeting of Secretaries and Reporters, and the subject of bulletins came up. The question of advertisements in the county bulletins came up and the consensus of the opinion expressed was that the bulletin was primarily for the medical profession and that it should be printed primarily for the doctors to whom it went.

Several criticisms have been brought to my attention about advertising habit-forming weeds, as we call it. Our girls and boys are more and more taking up tobacco, and we may be accused of advocating it through our medical journal. There are still a few doctors who do not use tobacco and there are quite a number of other persons who do not; and sometimes in our own official journal to have the advertising facing us in our journal is rather disturbing to some.

May I emphasize that our Journal is primarily for the doctors of New Jersey and not so much a money-making scheme. If the Publication Committee cannot support the publication without questionable advertisements, give it more money to print the Journal. We have the money. That is my viewpoint. (Applause.)

DR. BARKHORN: Our budget, of course, has no relation to our income so it makes no difference to the Publication Committee. We get $12,500. What we bring in goes into the treasury but has no relation to our budget. It is just in these times a serious consideration of the dues of fifty members. That is all.

The motion to adopt the Report of Reference Committee "B" was put to a vote, and was carried.

DR. PINNEO: My remark will be only to save time in the House of Delegates. This matter of Dr. Quigley's motion was in our minds and aired. Why repeat it again later? Can't we vote upon this amendment to the By-Laws now?

PRESIDENT ELY: What is your pleasure?

DR. MORRISON: Continue the routine of business.

PRESIDENT ELY: I think it would be better to come under New Business.

47. REFERENCE COMMITTEE "C"

We will continue with the Report of Reference Committee "C"—Dr. Edgar A. Ill, Chairman.

DR. ILL: Three members of the committee were present—Dr. George F. Dandois, Dr. B. G. Sherman, and the Chairman. We carefully read through the Reports of the Committees on Scientific Work, Program and Arrangements, Scientific Exhibits, Art and Hobby, and Delegates to the A. M. A.

The committee appreciates especially the work of these committees, and its outcome has proven its good quality. We have no recommendations to make, nor further suggestions.

DR. MORRISON: I move the report be concurred in.

The motion was seconded, was put to a vote and was carried.

48. REFERENCE COMMITTEE "D"

PRESIDENT ELY: Reference Committee "D" —Dr. A. A. Lawton.

DR. MORRISON: The report has been placed in my hands for reading.

Dr. Morrison read the report, as follows:

REPORT OF REFERENCE COMMITTEE "D"

I. Committee on Public Health

Sect. 23, and Journal, April, page 212

The report of the Committee on Public Health has been approved, and it is recommended that the Public Health Committee through the State Board of Education endeavor to enforce smallpox vaccination in the State.

II. The report of the State Board of Medical Examiners was unanimously approved. (Journal, April, page 225, and Sect. 24B.)

III. The report of the Committee on Maternal Welfare was approved unanimously with no further recommendations. (Journal, April, page 210, and Sect. 24A.)

IV. The report of the Committee on Hospitals and Medical Education (Sect. 22) was approved, and it was recommended that the suggestion of the President to divide the Committee on Hospitals and Medical Education into two separate parts be adopted. (Sect. 22, and Journal, April, page 210.) (See also Sect. 44, p. 54.)

V. The report of the Medical Advisory Committee to E. R. A. was approved (Sect. 24, and Journal, April, page 216), and it was recommended by Reference Committee "D" that the latter part of paragraph 5 of the agreement between The Medical Society of New Jersey and the State of New Jersey Emergency Relief Administration be supplemented to read as follows:

"Free choice of hospitalization in any accredited hospital shall be permitted when in the opinion of the attending physician hospitalization is necessary."

It is further recommended that the second part of paragraph 2 shall be made to read:

"The Emergency Relief Administration shall not suggest the name of any one physician. It *must* provide a roster of physicians, furnished by the County Medical Relief Advisory Committee from which the patient may make choice."

A. A. Lawton, Chairman,
David W. Scanlan,
H. D. Bellis,
C. H. Schlichter,
Louis A. Pyle.

DR. MORRISON: I move the adoption of the report.

The motion was seconded.

PRESIDENT ELY: It has been moved and seconded that the Report of Reference Committee "D" be adopted.

DR. HAWKES: Mr. President and Members: The committee that prepared this form hoped that it would be adopted as presented, not because we thought it to be a perfect product, but because it was prepared by a group of men who gave much thought to it and men who had been in close contact with E. R. A. medical work since its beginning.

The proposed change in paragraph 5 (p. 61), if it is meant simply as an elucidation of the meaning, is quite acceptable. If it is meant as that, it is not necessary, because paragraph 5 says the physician shall decide whether the patient requires hospitalization. What more do you want than that?

The medical plan is primarily to give medical treatment to the indigent sick. It is also to remunerate the doctor for his services, but the medical plan is not limited to the patient and the doctor. The medical plan is something new. It is a social experiment and like every other social experiment it will stand or fall depending upon the judgment of public opinion. If public opinion approves the plan as we administer it, it will stand. It will stand as long as such a plan is needed. If not, some other plan will be substituted.

As to hospitalization, before the E. R. A. came into existence, every hospital in our community had a plan of hospitalization, a plan for the admission of patients to a hospital. It was a plan that was acceptable to the hospital, acceptable to the patient, acceptable to the doctor and it was acceptable to the public. If this proposed change simply means clarification, it is not necessary.

But if it shall result in a change in the technic of the admission of a patient to a hospital, it is bound to cause trouble. It will meet with the opposition of the E. R. A. It will meet with the opposition of the hospitals and in the last analysis, if brought into light of day, it will meet with the disapproval of the public.

If the public think that we are instituting a plan, the sole purpose of which is not public service, but a litle additional income to ourselves, they are going to condemn us. Let us try to administer this plan as a public service for which we receive a partial remuneration and from which we shall eliminate every possible taint of unnecessary expense.

I, therefore, as a member of this committee, disapprove of that change as, in the first place, for clarification it is not necessary. If it will bring about a change in hospital admission, it is a very dangerous step.

DR. H. B. WILSON: Did I understand, Dr. Morrison, when he read the report, to say the patient should have free choice of hospitals, in that recommendation?

DR. MORRISON: That paragraph 5 be supplemented to read as follows:

"Free choice of hospitalization in any accredited hospital shall be permitted when in the opinion of the attending physician hospitalization is necessary." (P. 61.)

DR. WILSON: There seems to be a widely diverse method for the payment of hospitalization in this state under the Emergency Relief Administration. I do not know just what method they have of allocating funds to different hospitals. Some hospitals get nothing, some get $3 a day for taking care of emergency relief patients, some get $2 a day. I am informed by the Emergency Relief Administration in Bergen County that any resident of Bergen County who is hospitalized outside the limits of the county—the hospital receives $1 a day more.

DR. MORRISON: I object to this. It is not pertinent.

PRESIDENT ELY: We are not taking up any business on hospitalization. It is just the acceptance of a committee's report.

DR. WILSON: I should think, since the free choice of the patient as far as hospitals are concerned, is the recommendation of this committee, that it has something to do with it.

PRESIDENT ELY: It is just a question whether this will be adopted or turned down, that is all.

DR. WILSON: Am I out of order?

PRESIDENT ELY: I think that would come up under other business.

DR. WILSON: If this is adopted by the House of Delegates, what recourse have we then?

PRESIDENT ELY: The report of the committee may be questioned.

DR. NEWCOMB: I should think he is in order.

PRESIDENT ELY: All right.

DR. WILSON: The point I wanted to make is this: We only have a limited amount of funds with which to pay for this type of work and we do not know how long it is going to last. If we have to pay to the county, for example, $1 a day more for a patient than we do for hospitalization in our own county, it seems to me unwise that we should leave the choice of hospitals to the patient under this system. (Applause.)

DR. QUIGLEY: Mr. President, I move the adoption of this committee report, with the exception of the recommendation as to changed phraseology on the agreement with the E. R. A., which should be deleted.

The motion was seconded by Dr. Sprague, was put to a vote, and was carried.

49. REFERENCE COMMITTEE "E"

PRESIDENT ELY: Reference Committee "E" —Dr. Areson.

DR. MORRISON: The Report of Reference Committee "E" has been placed in my hands to read.

Dr. Morrison read the report.

REPORT OF REFERENCE COMMITTEE "E"

The Reference Committee "E" held a meeting last evening and presents this report of its survey of the Welfare Committee and its Sub-Committees:

I. The Welfare Committee

Journal, April, page 203, and Sect. 25

We endorse most heartily the report of this most important committee, particularly their prompt action in handling the emergency created by the first Physicians' Lien Law.

II. Legislation

Sect. 25A, and Journal, April, page 204

This committee is deserving of much credit in the passage of laws favorable to our profession and their efforts in blocking vicious legislation.

III. Medical Practice

Sect. 26, and Journal, April, page 204

This most excellent comprehensive report, covering as it does the various difficult angles of medical economics, is indeed worthy of the highest praise. We would direct every member of our Society to read and study most carefully this report. In endorsing it, we feel that the Chairman of this committee should be especially commended for this outstanding contribution to the medical problems of today.

IV. Uniform Medical Practice Act

Sect. 27, and Journal, April, page 209

The Chairman of this committee personally appeared before our committee and gave a very interesting report of his work.

His report was that of an intelligent progressive move to the solution of those problems connected with the practice of medicine by the various cults.

V. Workmen's Compensation Act

Sect. 27A, and Journal, April, page 207

This committee presented its usual excellent report and we are sure, if enacted into law, their recommendations, as they relate to the petitioner, the employers, and the physician, will result in greater benefits to all.

William H. Areson, Chairman,
Arcangelo Liva,
David B. Allman,
C. Byron Blaisdel.

Upon motion made by Dr. Quigley, which was regularly seconded, it was voted to adopt the report.

50. REFERENCE COMMITTEE "F"

PRESIDENT ELY: We will now hear the Report of Reference Committee "F"—Dr. Costello, Chairman.

Dr. LeRoy A. Wilkes read the report, as follows:

REPORT OF REFERENCE COMMITTEE "F"

I. The report of the Committee on Cancer was approved. (Sect. 28A, and Journal, April, page 219.)

II. The report of the Committee on Nursing and Nursing Education together with policies adopted by the State Medical Society of New Jersey and the State Organization of Public Health Nursing were unanimously approved. (Sect. 28.)

III. The report of the Committee on Honorary Membership was unanimously approved.

IV. The report of the Committee on Medical Defense was approved. (Sect. 29.)

William F. Costello, Chairman,
L. H. Bloom,
Nathan Swern,
B. T. D. Schwarz,
D. W. Green,
Lawton Cone.

DR. WILKES: I might say in connection with Nursing and Nursing Education, I happen to know the standing orders worked out by representatives of the State Medical Society and the nursing groups of the State of New Jersey were included in that report of the Nursing and Nursing Education Committee.

Upon motion made by Dr. Sprague, which was regularly seconded, it was voted to adopt the Report of Reference Committee "F".

51. PHYSICIANS' LIEN LAW

Sects. 20 and 45

PRESIDENT ELY: The Chair's attention has been called to the Committee on Physicians' Lien Law, that it has performed its function, and now it is a question whether it should be

discharged with the thanks of the House of Delegates.

DR. ULMER: I move, Mr. President, the Committee on Physicians' Lien Law be discharged with the grateful thanks of the Society.

The motion was seconded, was put to a vote and was carried.

DR. EAGLETON: That is rather a weak motion for what they have done.

PRESIDENT ELY: Offer an amendment.

DR. EAGLETON: I move the attention of the committee being discharged be called to the fact that this House regards that they have performed one of the most constructive pieces of work, for the interests of every doctor of the state, that has ever gone through this assembly.

PRESIDENT ELY: I think that is a very good addition. We will add that to the original motion and let it be so printed.

We will now proceed with New Business.

52. IMMUNIZATION AGAINST POLIOMYELITIS

DR. PINNEO: This communication was presented by request of the Pediatrics Session to the Scientific Session this morning. They heard Dr. Kolmer speak on the immunization against poliomyelitis. This is a communication from them, and reads as follows:

"In view of the recent progress made in the study of poliomyelitis, especially in preventive measures, it would perhaps come with good grace from the Pediatric Section, if the House of Delegates were asked to pass the following resolution:

"Resolved, That The Medical Society of New Jersey congratulate Drs. Kolmer, Park, and Brodie, who, after years of intensive study of poliomyelitis, have developed successful methods of immunizing susceptible persons against this most terrifying of all diseases.

"Be it further resolved, That The Medical Society of New Jersey looks with favor on the suggestion of the discoverers that observations of a sufficiently large group of immunized persons be carried on for a period of not less than three years, in order that the actual value of the vaccination be scientifically determined.

"And be it further resolved, That pursuant to the desire of the discoverers, a plan for making these observations, such as has been formulated by the Essex County Medical Society and the Babies Hospital in Newark, should be adopted also by The Medical Society of New Jersey to aid in the control of poliomyelitis."

Dr. Pinneo presented the following resolution:

"Resolved, that this House of Delegates approves the work of immunization against poliomyelitis as reported from the discoverers and as in operation under the Essex County Medical Society, and refers the matter for application throughout the State to our State Society Committee on Public Health for administration by a Sub-Committee of its own appointment."

PRESIDENT ELY: You have heard the resolution presented by Dr. Pinneo.

DR. PINNEO: I move its adoption.

The motion was seconded, was put to a vote, and was carried.

53. HOUR OF MEETING OF HOUSE OF DELEGATES

DR. PINNEO: There is another little item in my hands. In this matter of our Convention,—it is moved and the Trustees are hereby requested to plan the opening of the Annual Convention in the afternoon of the first day as voted by the House of Delegates in 1932 and followed with universal satisfaction in 1933 and 1934, instead of the morning of that first day.

The motion was seconded by Dr. Quigley.

PRESIDENT ELY: This Convention no doubt proves the value of this motion because those of us who were present on the morning of the first day, the opening of the House of Delegates, know we started with a very small number. The meeting was called for nine-thirty and we could not get a quorum until some time after ten o'clock. I think the motion is a good one.

DR. MORRISON: Before this motion is put. I wish you to remember this is going to entail an extra day's expense at Haddon Hall on the Delegates next year, if adopted. We cannot do the work of the House of Delegates in two sessions.

DR. QUIGLEY: I don't know. We did last year with perhaps not universal approval, but we did it. We had a session last year that was two days and a half. We did have some night sessions but they worked out pretty well.

DR. NEWCOMB: Why can't we have a session of the House of Delegates in the evening of the first day, afternoon and evening?

DR. PINNEO: That was one of the arguments for the original action and for two years before 1932 this was discussed among us. It did not come to action for the House of Delegates until individually approved by most of us. Dr. Newcomb has made a very good remark, that the purpose was, in beginning in the afternoon, to put a premium on the members of the Society getting here at the first important session of the reports.

Secondly, as the first evening did not entail any fixed engagement, we had that for overflow of business. Then it came for the Scientific Sections on the second day.

Calls for the question.

The motion was put to a vote and was carried.

54. AMENDMENT OF BY-LAWS

Sections 21, 37, 45 and 46

DR. QUIGLEY: May I bring up my subject now?

PRESIDENT ELY: Yes, Dr. Quigley.

DR. QUIGLEY: Unless there is some question, I will not again state the reason for the introduction of this. It is the deletion of Chapter 5, Section 2-B and the change in the wording of subsection D of this section, to read as follows:

"Nothing in this section is to be construed as preventing the nomination and election of fellows to the Board of Trustees."

I move the adoption of these two amendments.

DR. MARSH: Mr. President, I did not know that this amendment had been proposed the other day to the house. It has been ruled it has, I believe, but I understand there was no report from the Committee on Constitution and By-Laws when it was called, no supplementary report.

There are two reasons given by Dr. Quigley for suggesting this change. The second one, I think, is entirely valid—a mechanical reason. The other, I think, is practically valid, but I think there is another solution of this problem.

The Society consists, by the Charter and by the first section of the By-Laws, if you will notice, of the fellows, officers and delegates—three parts. The officers, by the By-Laws and Constitution, are members themselves of the Board of Trustees. There are a certain number of elected trustees, elected from the delegates. Formerly the entire body of fellows were members of the Board of Trustees. That became both unwieldly and in other respects undesirable.

However, I cannot agree with Dr. Quigley that the fellows as such are not entitled to representation. In the first place, the fellows are a selected group and a process group to use a modern term, that is to say, men who have for years been active and constructively active in the Society's work. They have been through a process of training in the President's Chair, as Dr. Quigley himself has done, as you have done now, sir. I think nobody will doubt either your opinion or the opinion of Dr. Quigley in matters of the Society organization are worth that of three of any ordinary members. Consequently, I think you are entitled to that consideration.

The solution that I have to offer is somewhat different from that offered by Dr. Quigley, that is, to increase the number of trustees by two. There is one trustee elected at large at the present time. Dr. Quigley is that trustee. Increase those by two and those elected from and by the fellows for terms of three years each, one every year. Then if two more trustees are elected from the delegates to take those places among the regularly elected trustees, Dr. Quigley has very correctly stated the mechanical difficulty at the present time is considerable.

In the first place, where a trustee is designated from the fellows, it deprives his district of one trustee that they are entitled to have. Secondly, it limits the fellows to their choice from a place where there happens to be a vacancy. They cannot choose a man from some other district if there is no vacancy.

The scheme I have suggested would correct that at least as well as the one he has, and would have the added advantage that it allows three trustees at large from different parts of the state. The one trustee we have at large now is a fellow. That is not necessarily a disadvantage. It would give the opportunity of electing a man. If Dr. Newcomb, for instance, has been through the mill he will be a fellow in a short time, as soon as this meeting adjourns. If his district has already two representatives in the Board of Trustees and it is desired to use his ability and his knowledge and experience, he can be elected by the fellows to that place.

I think, Mr. President, that scheme has advantages that entitle it to comparitson with the one Dr. Quigley has offered.

Dr. Quigley has moved adoption of this motion. I do not know what the parliamentary procedure would be, but I would like, if it is possible, to suggest a motion that the amendment offered by Dr. Quigley be referred back to the Committee on Constitution and By-Laws with the one I have outlined, for comparison and presentation next year, for it is not a matter of immediate haste.

PRESIDENT ELY: I may say for Dr. Quigley, his motion and recommendations were presented in writing to the Committee on Constitution and By-Laws, and approved. I have a copy of it in my files. Dr. Quigley called my attention to it previous to the Convention.

He sent me a copy of the proposed changes, and it is now up to the house to decide.

Dr. Quigley possibly knows the situation in the state better than any other man in the state, in regard to the requirements of the Constitution and By-Laws, and I think his motion is well taken.

There is a question before the house, unless Dr. Marsh wishes to make an amendment to that.

DR. MARSH: Under parliamentary procedure—

PRESIDENT ELY: It went through the regular channels, Dr. Marsh, through the Constitution and By-Laws Committee.

DR. MARSH: The whole matter to be referred back to the Committee on Constitution and By-Laws?

PRESIDENT ELY: No, they have already acted upon it and approved it.

DR. MARSH: They have approved it, but it is possible to refer it back.

PRESIDENT ELY: They have approved it.

DR. MARSH: I understand, but it is possible to refer it back for comparison with another suggestion.

DR. EAGLETON: We must understand that the only one who does understand this is Dr. Quigley and he framed the scheme whereby the fellows should have representation, but it happened in the framing of it he wanted the fellows to serve. However, in the operation of it, it has caused great embarrassment so that there has only been one meeting of the fellows since the new Constitution went into effect. I say that because I am the oldest fellow on the Board of Trustees.

It resulted in this—Essex County either had to do one thing or the other, insult a fellow or go unrepresented as it should be because of the district. Dr. Quigley is trying to correct this. He is the only one, I say, who has been on the inside to see how badly it works, and I do not think as long as it has gone through the regular channels—well, I am sure this house should adopt it.

DR. MARSH: Mr. Chairman, may I say that I recognize the difficulty and my suggestion remedies that difficulty exactly as thoroughly as Dr. Quigley's, but in a different way. Our parliamentary authority, the President-Elect, says it is perfectly possible to refer this back to the Committee on motion.

DR. NEWCOMB: Mr. Chairman, as far as parliamentary procedure, we in the Legislature can refer anything back to second reading for amendment. It may be on the Board for third reading, but by motion you may refer it back to second reading for amendment, or you may refer it back to committee for amendment and have it reported out in the usual form.

PRESIDENT ELY: We have it here in writing. It has gone through the regular form.

DR. QUIGLEY: I want to say there is no trouble, if it is desired to have it referred back again for further study, but I would like to say this: Experience has proven that this provision is unnecessary. The Nominating Committee and the House of Delegates, since the adoption of this, have recognized that it is desirable to have some fellows as trustees, and they have, regardless of this provision, selected three former Presidents as trustees, which shows the lack of necessity for it.

If a fellow is active enough following the completion of his term and the Nominating Committee and House of Delegates feel he is of continuing value, that is up to them to put him on. Why force somebody on? There is no necessity for it; and then, as Dr. Marsh has said, the mechanical difficulties are plainly apparent.

I see no reason for increasing the number of trustees. I think our Board is large enough. We have eleven, and six officers. That is a Board of seventeen. That is a large Board as Boards of Trustees go.

PRESIDENT ELY: There is a motion before the house, as presented by Dr. Quigley.

The motion was put to a vote, and was carried.

PRESIDENT ELY: Is there any other New Business?

55. C. C. C. Camp Doctors and Private Practice

DR FREDERICK P. WILBUR (Sussex): As Secretary of Sussex County, it has been brought to my attention that Dr. Eddy, who is a full-time surgeon in the Civilian Conservation Corps Camps at High Point, has opened an office in Sussex for general practice of medicine, has put his sign out, and is practicing medicine, contrary to the regulations.

As the same sort of thing may happen in the rest of the state, we felt in Sussex County that it should be referred to the Secretary of the State Society, to communicate with the Army, disciplining this particular individual for practicing medicine besides being a full-time army officer, in the C. C. C. camps.

PRESIDENT ELY: The question would be referred, would it not, Dr. Wilbur, to the

Board of Medical Examiners to make an investigation?

Dr. Wilbur: He is licensed to practice and registered in Sussex County.

President Ely: I think there is some provision made for army and navy officers in the Medical Practice Act.

Dr. Wilbur: There is. It distinctly forbids a man opening an office who is practicing as a full-time surgeon in the C. C. C. camps.

President Ely: What action do you care to take on Dr. Wilbur's report? I think it is really in the hands of the Medical Examining Board to make further investigation.

It was regularly moved and seconded that the matter be referred to the Medical Examining Board for further investigation.

Dr. Snedecor: For Dr. Wilbur's benefit, I think there is another way of approaching the subject. Since this man is employed full time through the C. C. C. camps, I think we can control it through the Emergency Relief Administration. They will soon see that he does not do ony outside practice. It is against his contract.

The motion was put to a vote, and was lost.

56. Dr. Eagleton and the Pan American Medical Association

President Ely: Is there any other New Business? If not, we will turn to Miscellaneous Business.

The Pan American Medical Association meets in Brazil in the early part of July. It has come to the Chair's attention that Dr. Eagleton expects to attend that Convention. I think it would be a very good thing for the house to appoint him as a special delegate representing the New Jersey State Medical Society. I will entertain such a motion.

Dr. Pollak: I so move.

The motion was seconded by Dr. Snedecor, was put to a vote, and was carried. (Applause.)

57. Place of A. M. A. Meeting 1936

Dr. Morrison: Kansas City extends an invitation to the American Medical Association to meet in Kansas City in 1936.

Dr. Morrison read the telegram extending the invitation.

Dr. Pollak: I move the question of the designation of the meeting place of the A. M. A. be left to the discretion of the delegates from New Jersey to the A. M. A. Convention.

The motion was seconded, was put to a vote, and was carried.

58. Annual Meeting New Jersey State Society

President Ely: I presume it would be in line for us to consider the meeting place for our next convention in 1936.

Dr. Snedecor: I move that this Society meet in Atlantic City in 1936 for its annual session if possible in June at Haddon Hall.

Dr. Eagleton: Why limit the committee who do all the work? Let them meet in Haddon Hall or any other hall that they may select. They are the ones.

Dr. Snedecor: Merely in Atlantic City in 1936, preferably the month of June.

Dr. Newcomb: Other years we have designated the hotel.

Voice: Preferably Haddon Hall.

President Ely: We have agreed to meet in Atlantic City at Haddon Hall. Do you accept the amendment?

Dr. Snedecor: I do.

The motion was put to a vote and was carried.

59. Adjournment

President Ely: The Chair takes this opportunity to thank the different Reference Committees for the work they have performed and also the other committees, during the Convention. There is also a personal thank you to every member who has aided in the success of this Convention.

The adjournment of the 169th Convention is in order. Upon motion, unanimously carried the meeting adjourned at four-thirty o'clock.

Lancelot Ely, *President*.
J. Bennett Morrison, *Secretary*.

Part 2.

THE SCIENTIFIC SESSIONS

GENERAL MEETINGS

Wednesday, May first, was devoted to general scientific meetings in a morning and an afternoon session, each of which was of great interest and well attended.

MORNING SESSION

Four speakers were intrduced at the morning session by President Ely, who presided. The first paper was given by Dr. Homer I. Silvers of Atlantic City, on the subject "Lympho-Granuloma Inguinale as a Causative Factor in the Production of Rectal Strictures." Dr. Silvers read a prepared paper, and then showed nine lantern slides illustrating various phases of the condition.

The second paper was to have been given by Dr. David D. Berlin of Boston, Massachusetts, on the subject "The Treatment of Chronic Heart Disease by Total Thyroidectomy"; but he was unable to be present on account of illness, and therefore sent Dr. J. A. S. Reeseman, of Boston, who described the results of the operation in one hundred cases at the Beth Israel Hospital, Boston.

Dr. Reeseman lectured largely from lantern slides. The results which he described were encouraging, and will be set forth in a paper which will be published in this Journal.

The third address was given by Dr. George Crile, Cleveland, Ohio, on the subject "Polyglandular Disease". Dr. Crile lectured in a conversational way, and described the interrelations of the ductless glands, especially the thyroid, the adrenal, and the pituitary. He described some striking improvements following cutting the splanchinc nerve supply of the adrenals. He explained the relation of the glands to chronic diseases such as diabetes and peptic ulcer, and showed lantern slides of cases.

Dr. Crile's address was of peculiar interest and value, and will be published in this Journal.

The fourth paper was given by Dr. B. Franklin Busby, of Camden, on the subject "Acute Osteomyelitis".

Dr. Ely then introduced Dr. Walter L. Bierring, Des Moines, Iowa, President of the American Medical Association, who spoke of the educational work of medical societies along economic as well as scientific lines.

Dr. Ralph K. Hollinshed, Westville, Chairman of the Committee on Scientific Work, presided during part of the morning session.

AFTERNOON SESSION

The second general scientific session convened at half past two o'clock. President Ely presiding.

The first speaker was Dr. Earl LeRoy Wood, of Newark, who gave a paper on "Functional Rest of the Nose in the Treatment of Upper Respiratory Infections".

The second paper was read by Dr. Paul Dudley White, of Boston, on the subject "Coronary Disease in Young People".

The third paper was read by Dr. James B. Herrick, of Chicago, Illinois, on the subject "The Error of Diagnosing other Diseases as Coronary Thrombosis".

The fourth paper was given by Dr. Robert A. MacKenzie, of Asbury Park, on the subject "The Causes and Management of Premature Labor". This paper was discussed by Dr. Julius Levy, of Newark, Dr. Arthur W. Bingham, of East Orange, and Dr. T. W. Corwin, of Newark.

Dr. Spencer T. Snedecor, Hackensack, Second Vice-President, presided during part of the afternoon session.

All the papers in the General Session were of great interest and practical value, and will be published in this Journal for the benefit of the entire medical profession of New Jersey.

THE SCIENTIFIC SECTIONS

Thursday morning and afternoon were devoted to meetings of the four scientific sections, which have been officially established by The Medical Society of New Jersey.

1. Eye, Ear, Nose and Throat
2. Pediatrics
3. Radiology
4. Gastro-Enterology.

SECTION ON EYE, EAR, NOSE AND THROAT

James A. Fisher, M.D., Chairman
W. K. Campbell, M.D., Secretary

The meeting was called to order at 9.45 a. m. Dr. J. A. Fisher in the chair, with 19 members present.

A paper was given by Dr. Charles W. Barkhorn of Newark:—"Clinical Versus X-Ray Study in Acute Mastoiditis". Discussion was opened by Dr. W. James Marquis of Newark, followed by Dr. Samuel J. Kopetzky of New York City, and then by Dr. Henry C. Barkhorn of Newark. Discussion closed by Dr. C. W. Barkhorn.

Second paper:—"External Fronto-Ethmo Sphenoid Operation" and presentation of patient, by Dr. Oram R. Kline of Camden. 28 Members present. Discussion opened by Dr. R. A. Luongo of Philadelphia, who gave a talk illustrated by lantern slides, showing the technique of the operation. Dr. N. W. Burritt of Summit followed and Dr. Kline closed the discussion by answering questions that were asked.

Dr. E. L. Wood of Newark was given the floor to illustrate a device for a method of treatment for the Eustachian tube.

The third program paper was presented by Dr. S. J. Kopetzky, of New York, on "The Influence of Bone Structure on Purulent Lesions of the Temporal Bone". Forty members present. The discussion was opened by Dr. Wells P. Eagleton, of Newark, who was followed by Dr. Henry Barkhorn. Dr. Kopetzky closed the discussion.

The afternoon session was called to order by the chairman, Dr. J. A. Fisher, at 2.40 p. m.

The Nominating Committee's report, signed by Doctors H. R. North and H. B. Orton, was presented, nominating Dr. C. Coulter Charlton for the chairmanship, and Dr. H. L. Harley for the secretaryship, both of Atlantic City. No nominations being made from the floor, the ballot was cast and Dr. Charlton and Dr. Harley received the unanimous vote of the Section.

The first paper was presented by Dr. William H. Hahn of Newark:—"The Treatment of Cataract in History". 24 Members present.

The second paper by Dr. A. B. Reese of New York City:— "Operative Treatment of Squint", was presented, with 22 members present. The discussion was opened by Dr. A. E. Sherman of East Orange, followed by Dr. C. Littwin of Englewood.

The third paper of the afternoon was presented by Dr. George H. Cross of Chester:— "Intra-Ocular Non-Magnetic Foreign Bodies with Special Reference to Their Removal" with 20 members present. Dr. Cross also presented lantern slides showing results of operations, the technique, and also the instruments used. He also showed the instruments themselves, which he had devised. Discussion was opened by Dr. E. S. Sherman of Newark. Dr. A. E. Sherman followed, citing cases. Dr. D. M. Yazujian of Trenton cited cases. Dr. Cross closed the discussion.

The fourth paper was by Dr. W. G. Mengel of Camden:—"Infantile Glaucoma", with 12 present. Dr. Mengel presented a series of slides illustrating his paper. Dr. Littwin of Englewood discussed the paper.

Adjournment at 5.30 p. m.

The secretary would call the attention of the Executive Committee to the fact that usually the Section Secretary is not a stenographer, and that it is exceedingly difficult to make proper notes on the discussion of papers, and would suggest that if there be any way possible to finance a stenographer for the section meeting, that this be done, as many times the discussion is very instructive and adds to the substance of the paper.

There were forty-five members who signed the Register for this Section.

Wm. K. Campbell,
Secretary.

SECTION ON RADIOLOGY

Elwood E. Downs, Woodbury, Chairman
P. S. Avery, New Brunswick, Secretary

The Section on Radiology held the meetings as indicated in the Official Program of The Medical Society of New Jersey at the annual meeting on May 2nd, 1935, with the Chairman, Dr. Elwood E. Downs, Woodbury, presiding. The morning meeting consisted of a symposium on primary carcinoma of the lung, the subjects and speakers being as follows:

Roentgen Diagnosis, William Klein, M.D., New Brunswick.

Endoscopic Study, Henry B. Orton, M.D., Newark.

Histological and Pathological Diagnosis, Sylvan E. Moolten, M.D., New York. N. Y.

Surgical Aspect, Richard Dieffenbach, M.D., Newark.

Roentgen Therapy, Milton Friedman, M.D., Newark.

We are anxious to have the papers of this group printed in The Journal as a symposium.

The afternoon meeting was confined to a symposium on roentgen diagnosis in childhood and adolescent tuberculosis. At that meeting Dr. Maurice McPhedran, Philadelphia, Pa., gave a most interesting discussion, but did not read a paper. The other two papers were:—

Clinical Manifestations, Samuel B. English, M.D., and J. Gross, M.D., Glen Gardner.

Pathological Findings, Chester R. Brown, M.D., Arlington.

The Section officers for the coming year are:—

Chairman, William G. Herrman
Secretary, P. S. Avery.

P. S. AVERY,
Secretary.

SECTION ON GASTRO-ENTEROLOGY AND PROCTOLOGY

Julius Gerendasy, M.D., Chairman
Sigurd W. Johnsen, M.D., Secretary

The meeting was called to order by the chairman, Dr. Gerendasy, at 9.50 a. m. The first paper presented was "The Relation of Gall-Bladder Diseases and Gall Stones to Myocardial and Coronary Diseases and Angina Pectoris" by Hyman I. Goldstein, M.D., Camden. Discussion was opened by Dr. H. E. Behrens, Jersey City. The following participated in the discussion: Drs. Wolf, Danzis, Polevski, and Corn. Dr. Goldstein closed the discussion.

The next paper presented was "The Management of Colitis" by Manfred Kraemer, M.D., and Maurice Asher, M.D., Newark. Discussion was opened by Dr. Rudolph V. Gorsch, Adj. Prof. Proctology at the Polyclinic Medical School and Hospital, N. Y. C. Others participating were Drs. Sharpe, Danzis, Corn and McLaughlin.

The next paper was "Clinical Interpretation of Jaundice" by Victor Knapp, M.D., Asbury Park. Discussion was led by Dr. Danzis and Dr. Beisler.

The fourth paper presented was "Common Disorders of the Digestive Tract, a Clinical and Roentgenographical Study of 500 Consecutive Private Cases" by Sigurd W. Johnsen, M.D., Passaic. Discussion was led by Dr. Daniel Leo Haggerty, Trenton. Drs. Lippincott and Danzis also participated in the discussion.

The next paper presented was "The Surgical Treatment of Massive Hemorrhage from Peptic Ulcer" by L. G. Beissler, M.D., Newark. Dr. Max Danzis led the discussion.

The session was then adjourned, after the Chairman appointed Dr. Goldstein, Dr. Kaplan, and Dr. Kraemer as the Nominating Committee to nominate officers of the Section for the coming year.

The second session was opened by the Chairman at 2:40 p. m. The report of the nominating committee was received. Sigurd W. Johnsen, M.D., Passaic, was nominated as Chairman, and Louis L. Perkel, M.D., Jersey City, Secretary; and the nominees were unanimously elected.

In the afternoon, Dr. Emanuel Libman, of Mount Sinai Hospital, New York City, gave the first paper of the afternoon, on "The Diagnostic Studies in Pain with Reference to the Abdominal Disorders". Dr. Hyman I. Goldstein led the discussion. Others who fol-

lowed were Drs. Gorsch, Gordon, Corn, and Danzis.

Dr. Louis L. Perkel then gave a very interesting lantern slide demonstration of "X-Ray Demonstration of Unusual Gastro-Intestinal Lesions".

The next paper was, "The Relation of Colitis to Chronic Appendicitis," by C. D. Smith, M.D., Paterson. Discussion was opened by Dr. Gorsch, and Dr. Frank C. McCormack.

The last paper was "The Modern Proctologic Clinic. Management of Common Conditions" by Martin J. Synnott, Montclair. Discussion was opened by Dr. J. L. Mathesheimer, Jersey City. Dr. Gorsch and Dr. Smith participated in the discussion.

The marked interest and excellent attendance at this, the first session of the Section on Gastro-Enterology and Proctology, has been a great inspiration to the officers and others interested in the advancement of gastro-enterology.

SIGURD W. JOHNSEN,
Secretary.

SECTION ON PEDIATRICS

Frederick W. Lathrop, Chairman
F. J. Krauss, Secretary

The Section on Pediatrics of The Medical Society of New Jersey held two sessions on Thursday, May 2, 1935, with Dr. Frederick W. Lathrop, Plainfield, President, in the Chair, and Dr. F. J. Krauss, Chatham, Secretary.

The following program was carried out:—

"Schuller-Christian's Disease", by Sandor A. Levinsohn, M.D., Paterson.

"Congenital Abnormalities of the Alimentary Tract Occurring in the Premature and New-Born Infant", by Benjamin M. Joseph, M.D., Jersey City.

"Childhood Tuberculosis,—Contact Histories and the Lowenstein Test", by M. James Fine, M.D.

The paper aroused an interesting discussion, which was led by Dr. S. B. English, Glen Gardner.

The fourth paper on the morning's program, that on "A Successful Method for Vaccination Against Acute Anterior Poliomyelitis", was the outstanding contribution to the Pediatric Section. The author, Dr. John Kolmer, of Philadelphia, gave convincing evidence that a successful method of vaccination against this dread disease has at last been attained. His paper was very enthusiastically received by a large audience.

Three papers were given during the afternoon session:—

"The Relationship of Urban Living Conditions to Temperament", by J. S. Plant, M.D., Newark.

"Developmental Language Disabilities in Children", by Paul Dosier, M.D., New York, N. Y.

"The Institutional Treatment of the Epileptic Child", by Banks S. Baker, M.D., Skillman.

The papers were excellent in content and well delivered, but the attendance was small, for the House of Delegates held its final meeting at the same hour.

The nominating committee composed of Walter B. Stewart, and Dr. William London, nominated Dr. F. J. Krauss for Chairman, and Dr. Chester R. Brown, as Secretary, for the ensuing year. The candidates were unanimously elected.

FREDERICK W. LATHROP,
Chairman.

Part 3.

MINUTES OF THE WOMAN'S AUXILIARY

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1. INTRODUCTION

The *Woman's Auxiliary to The Medical Society of New Jersey* held its eighth annual meeting in Haddon Hall, Atlantic City, in connection with that of the State Medical Society, on April 30, May 1 and 2, 1935, with 138 members registered.

The Auxiliary had its own lounge rooms in which the articles of the Art and Hobby Exhibit were displayed, thereby adding to the attractiveness of the headquarters.

The events were carried out in accordance with the announcements contained on pages 240 and 241 of the April Journal. The meeting was most interesting and successful.

2. PRESIDENT'S REPORT

By MRS. A. J. CASSELMAN, Camden, N. J.

For the first time in the history of the Auxiliary, a report of its activities has been included in the annual reports of The Medical Society of New Jersey, the report of your President having been printed on pages 227-229 of the April number of The Journal. In that report your President emphasized those activities which were in support of projects already sponsored by the State Society. Please consider that report to be the official communication of your President to you, in regard to the major activities of our Auxiliary.

It is evidence of marked progress that The Medical Society of New Jersey recognizes the assistance of the Auxiliary as an essential contribution in carrying out its projects, especially in the Speakers' Bureau.

The year's work has been unusually difficult. I shall always remember the pleasant side that this office carries, the kind, thoughtful messages that seemed to come at just the right time, and I shall always treasure the friendships I have made.

I take this opportunity to thank the members of the Executive Board, who have given me their support and coöperation.

I have not visited all organized counties, but those which I have visited have a faithful and loyal membership and are doing a fine work.

We need a full membership in every county.

There should be a concerted membership drive. It seems to me there should be an auxiliary representative for every member of the County Medical Society. The Auxiliary needs more organization and more members, and we need recognition and assistance from the State Medical Society, if we are to keep our own members.

I thank you for having given me the opportunity to serve as President of the Medical Auxiliary.

To my successor I give my sincere congratulations and best wishes. I ask you all to stand by her and help her make this Medical Auxiliary one of the best in the Nation.

Respectfully submitted,

ZULA MAE CASSELMAN,
President.

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3. PRESIDENT'S INAUGURAL ADDRESS

By MRS. FREDERICK A. KINCH, Westfield, N. J.

Some speakers compare their organization to a ship sailing in all its majesty; others to a railroad train pushing along at top speed. Let us today liken our Auxiliary to the Airplane; what mode of travel or transportation is more graceful or speedy than the ship of the air? And so it is with the Medical Profession; what a few years ago was considered all right, is now cast into the discard. This is an age of progress, advancement and education.

The Auxiliary of the State of New Jersey starts in its ninth year. It has steadily grown in strength, in usefulness, and in power. The success of the organization has been due to the devotion of its members, the splendid work of its committees, and the excellent leadership of its presidents and officers.

We want the influence of the Auxiliary felt in every community large or small. The best way to attain this end is by educating the people. It is not our intention to make doctors of them, but we want them to know the difference between the true and the false; to take care of their health; to know when to send for their physician, and to avoid the "isms" and "pathies" that are so much advertised and explointed by newspaper, magazines and the radio.

Your President has no special plan of work for the year, except to continue along the lines so ably started by her predecessors, and to carry on the work outlined by the National Auxiliary and the Advisory Council.

You all know of the outstanding activities of the Auxiliary,—the Speakers' Bureau, the Widows' and Orphans' Fund, the Public Welfare and Education along Medical Lines, and the Student's Loan Fund. Your attention will be called to these worthy objects during the coming year through your committees.

I thank you for the honor bestowed me in making me your President. I need your help and sympathy, especially sympathy, for you already have mine. With the coöperation of the officers, committees, and members, I feel confident that we will go forward to a most successful year.

I have the honor and pleasure of announcing the appointment of Mrs. George S. Laird as Corresponding Secretary, and Mrs. Harold D. Corbusier, Parliamentarian; and the following Chairmen of committees:

CHAIRMEN OF COMMITTEES

Publicity and Reporter to State Journal—Mrs. Frank Nicholson, 495 Summit Avenue, Jersey City.

Program—Mrs. Dan S. Renner, Skillman

Public Health—Mrs. Don D. Epler, 45 Hillside Avenue, Newark

Entertainment—Mrs. Samuel Salasin, 511 Pacific Avenue, Atlantic City

Credentials—Mrs. Carl A. Surran, Prof. Arts Bldg., Atlantic City

Public Relations—Mrs. A. Haines Lippincott, 406 Cooper Street, Camden

Legislation—Mrs. James J. McGuire, 122 W. State Street, Trenton

Organization and Membership—Mrs. Harry V. Hubbard, 121 E. Seventh Street, Plainfield

Widows and Orphans Society—Mrs. Theodore Teimer, 17 Hillside Avenue, Newark

Historian and Archives—Mrs. James Hunter, 104 Station Avenue, Westville

Hygeia—Mrs. James Mason, 44 S. Tallahassee Avenue, Atlantic City.

Resolutions—Mrs. George L. Orton, 98 Elm Avenue, Rahway.

Nominating—Mrs. A. J. Casselman, 301 N. Second Street, Camden.

Parliamentarian—Mrs. Harold D. Corbusier, 612 Park Avenue, Plainfield.

4. BUSINESS SESSIONS

The first Business Meeting was held on the morning of Wednesday, May first, when the following program was carried out:

Call to Order—President, Mrs. A. J. Casselman.
Roll Call.
Tribute to Departed Members—Mrs. James Hunter, Jr.
Reading of Minutes—Recording Secretary, Mrs. Marcus Newcomb.
Report of Treasurer—Mrs. Edward Clarke.
Report of Corresponding Secretary—Mrs. O. W. Carlander.
Report of Standing Committees (see page 79).
Report of Nominating Committee (see page 77).
Election of Officers.

A luncheon was given at one o'clock at which honored guests were formally introduced.

The second Business Meeting was held on Wednesday afternoon, when the following program was carried out:

Reports of County Auxiliary Presidents.
Unfinished Business.
Report of President—Mrs. A. J. Casselman (see page 72).
Installation of Officers.
Inaugural Address—Mrs. Frederick Kinch, President 1935-36 (see page 73).
Appointment of Committee Chairmen.
Adjournment.

5. THE BANQUET

The evening of Wednesday, May first, was given over to the formal banquet and ball in honor of Dr. Lancelot Ely, President of The Medical Society of New Jersey. This was conducted under the auspices of the Woman's Auxiliary to The Medical Society of New Jersey, and was described in the May Journal, page 312.

6. THE ART AND HOBBY EXHIBIT

By Mrs. Louise S. Corbusier, Plainfield

The Arts and Hobby Exhibit of The Medical Society of New Jersey was held in the Derbyshire Room, the headquarters of the Auxiliary, on the first floor of Haddon Hall. The room was furnished so that it proved a comfortable place for people to meet and sit awhile, and the tea, served on Wednesday afternoon, gave the exhibit a pleasant social aspect.

One hundred and fifty-two items were displayed by the following physicians and members of the physicians' families:

Mrs. David B. Ackley—Pictures and hand-made jewelry.
Dr. Christopher Beling—Pictures in oil and in crayon.
Dr. H. D. Corbusier—Collection of arms.
Mrs. H. D. Corbusier—Ancient Peruvian textiles.
Miss Mary Lea Davis—Pictures and pottery vase.
Dr. Lancelot Ely—Indian relics.
Dr. David Farley—Sculptured bust.
Mrs. Frederick Frisch—Antique crocheted crib cover.
Dr. Frederic J. Hughes—Two paintings in oils.
Mrs. James J. Hunter—Physician's bill for services 1832.
Dr. Siegfried Husserl—Sculptured figures and heads.
Mrs. E. W. Jacquemont—Hand-woven articles and jewelry.
Dr. Harold F. Johnson—Two paintings in oils.
Dr. M. J. Kaufman—Group of paintings.
Dr. George S. Laird and Mrs. Laird—Hand-made jewelry.
Miss Mary Lee—Silver jewelry.
Mrs. D. Maver—Three oil paintings.
Dr. W. B. Mount—Collection of antique instruments.
Dr. Louis L. Perkel—Photographic studies.
Miss Elizabeth Spencer—Painting in oils.
Mrs. Blair Stewart—Old quilt and coverlet, and antique china.
Dr. Sloan Stewart—Pastel.
Mrs. Henry Tatum, Jr.—Knitted suits.
Miss Carolyn Teimer—Pictures in oils.
Mrs. David F. Weeks—Needle-point bag.
Dr. Laurence A. Wilson—Model engine.

Several people who had signed entry blanks of articles to be exhibited were unable to show them, and we hope to have these at the next exhibit.

The Exhibit opened on Tuesday evening and closed after the section meetings on Thursday. The attendance was large, the number of visits amounting to about 677, of whom 480 were counted on Wednesday. The very real interest shown promises continued growth in the success of these Arts and Hobby Exhibits and we anticipate a larger number of entries for next year.

Please remember that not only physicians,

but members of their families are eligible to exhibit. Two types of entries are acceptable, work that is produced as an avocation, and collections such as items of curious, aesthetic, antique, or historic interest.

The committee hopes that those who have exhibited will continue to do so, and that many more will be added to the list of exhibitors. Hobbies are more and more essential to the well-being of busy people; the Exhibit illustrates what things are interesting as avocations, and the idea is worth developing. Keep it in mind for next year.

Respectfully submitted,
LOUISE S. CORBUSIER, *Chairman*,
Art and Hobby Exhibit.

See Transactions House of Delegates, Sections 28 and 47.

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7. THE EXECUTIVE COMMITTEE MEETING

By Mrs. Dan S. Renner, Skillman

A meeting of the Executive Board was held on the evening of Tuesday, April 30, with twenty-seven members present, as follows:

Mrs. A. J. Casselman—President.
Mrs. Frederick Kinch—President-Elect.
Mrs. Edward Clarke—Treasurer.
Mrs. Dan S. Renner—Recording Secretary Pro Tem.
Mrs. William A. Freile—First Vice-President.
Mrs. James Mason—Second Vice-President.
Mrs. Harold Corbusier and Mrs. William K. Campbell—Directors.

Chairmen of Committees

Mrs. Don Epler—Public Health
Mrs. Samuel Salasin—Entertainment.
Mrs. David B. Allman—Credentials.
Mrs. James McGuire—Legislature.
Mrs. Harry V. Hubbard—Organization and Membership.
Mrs. Theodore Teimer—Widows' and Orphans' Society.
Mrs. James Hunter—Historian and Archives.
Mrs. Thomas P. McConaghy—Hygeia.
Mrs. George Orton—Resolutions.
Mrs. H. Roy Van Ness—Nominations.
Mrs. Theodore Teimer—Auditing.

County Presidents

Mrs. James North—Atlantic
Mrs. Alvah Bickner—Bergen
Mrs. G. E. McDonnel—Burlington
Mrs. Don Epler—Essex
Mrs. Frank P. Nicholson—Hudson
Mrs. W. K. Campbell—Monmouth
Mrs. Lancelot Ely—Somerset
Mrs. F. B. Gilpin—Union

The minutes of this Executive Meeting were as follows:

A meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held April 29, 1935, at 8:30 p. m. in the Garden Room, Haddon Hall, Atlantic City, the President, Mrs. A. J. Casselman, presiding.

The minutes of the March 11th meeting were read and approved.

The Treasurer's report for the quarter was read and received. It is enclosed with the minutes.

Mrs. Casselman asked if it was the wish of the Executive Board that the special contribution to the Annual Meeting fund for use in helping to defray the expenses of the Auxiliary to the American Medical Association be added to the $200.00 appropriated. It was decided that because of the depleted condition of the Annual Meeting Fund that only $200.00 be used. That more than $50.00 granted Mrs. Mason for her expenses for entertainment for the State Meeting would probably be necessary.

The President, Mrs. Casselman, explained that it was more convenient for her to carry on the correspondence from her office than to use a Corresponding Secretary, and that she hoped that this procedure met with the approval of the Board.

The President asked what should be done about getting information of the transactions of the Executive Board Meetings to the members who were unable to be present. She suggested that the new Board consider this and perhaps bring it up at the next Board Meeting.

Mrs. Corbusier moved that the minutes of the previous Executive Board meetings, together with important material on hand, be turned over to the Historian, Mrs. James Hunter, to be sorted and then forwarded to the office of the State Medical Society to be filed. Mrs. Nicholson seconded this motion which was then carried.

Mrs. Casselman reported that Dr. Dan S. Renner, Chairman of the Advisory Board of the State Medical Society, had asked that the Woman's Auxiliary take over the *Health Hour Program* of the State Medical Society; that each Auxiliary should have the sanction of its County Medical Society before taking action. Mrs. Don Epler was asked to explain what this Health Hour meant. She also explained how effectively it had worked in Essex County, and reported that it had meant much hard work to put it across.

Mrs. McDonnel reported that the Burlington County Medical Society had not approved of the program.

Mrs. Don Epler reported that the Woman's Auxiliary of Essex County was asked by their County Medical Society to protest against Dr. Hay speaking in Kresges' Department Store. A committee attended the lectures and reported ridiculous statements having been made by Dr. Hay. They protested to the manager of Kresges' store and were told to write a letter of protest to the Dry Goods Stores Association, which they did. Mrs. K. C. For-

sythe was to report at the General Meeting on Wednesday, if she were able to attend. She was to read a paper, which was taken in shorthand at the second lecture. The Medical Society was reported as still working on the case.

Mrs. Hubbard reported that there was nothing to be presented on the Constitution and By-Laws.

Mrs. Tomlinson, President of the Woman's Auxiliary to the American Medical Association, stated that their Constitution and By-Laws would probably be ready for presentation before the House of Delegates in June; that the name of the Auxiliary would not be changed.

Mrs. Edward Clarke moved that we correct the Constitution and By-Laws which we now have, by adding "and County Presidents" in Section 1, Executive Board, Page 7, and pasting over the names at the end on page 10 and crossing out "proposed" on the cover. This was seconded and carried.

Mrs. Frederick Kinch, President-Elect, read the names of her Committee Chairmen for 1935-1936 for the Board's approval. Mrs. Don Epler moved that these Chairmen be approved as named. This was seconded and carried.

Respectfully submitted,

Clara C. Renner,
Secretary Pro Tem.

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8. MINUTES OF THE ANNUAL MEETING

By Dan S. Renner, Skillman, N. J.

The eighth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Garden Room of Haddon Hall, Atlantic City, May first, 1935, the President, Mrs. A. J. Casselman, presiding. The meeting was called to order at 9:45 a. m.

In the absence of the Recording Secretary, Mrs. Newcomb, Mrs. Dan S. Renner was appointed Secretary Pro Tem.

Roll Call of Departed Members.—Mrs. James Hunter conducted a very impressive ceremony in which tributes were paid to six members who have passed to the Beyond during the year: A white carnation was placed in a vase on the desk by a representative of each county, as the following names were called: Mrs. Westcott, Camden; Mrs. Charles Ripley, Essex; Mrs. John Mooney, Hudson; Mrs. James Enright, Hudson; Mrs. Emerson Haines, Monmouth; Mrs. William Donovan, Monmouth.

A letter of regret was read from Mrs. Newcomb, our Recording Secretary, explaining that because of illness she was unable to be present.

A telegram was read from Mrs. Nevin, regretting her inability to attend the meeting and extending best wishes to the Auxiliary.

The minutes of the June fourth meeting were read, which with proper corrections, were approved and accepted.

On roll call the following responded:

Mrs. A. J. Casselman—President
Mrs. Frederich Kinch—President-Elect
Mrs. Edward Clarke—Treasurer
Mrs. William Freile—First Vice-President
Mrs. James Mason, Second Vice-President

Chairmen of Committees

Mrs. Dan S. Renner—Program
Mrs. Don E. Epler—Public Health
Mrs. Samuel Salasin—Entertainment
Mrs. David B. Allman—Credentials
Mrs. A. Haines Lippincott—Public Relations
Mrs. James McGuire—Legislation
Mrs. Harry Hubbard—Organization and Membership
Mrs. Theodore Teimer—Widows' and Orphans' Society
Mrs. H. Roy VanNess—Nomination

County Presidents

Mrs. James North—Atlantic
Mrs. Alvah W. Bickner—Bergen
Mrs. G. E. McDonnel—Burlington
Mrs. Edward Pechin—Camden
Mrs. Don A. Epler—Essex
Mrs. Frank P. Nicholson—Hudson
Mrs. A. S. Fell—Mercer
Mrs. W. Campbell—Monmouth
Mrs. Lancelot Ely—Somerset
Mrs. H. H. Bowles—Union

The Treasurer's report was read by Mrs. Edward F. Clarke, which gave a balance for the year ending May first, 1935, of $316.41, of which $174.69 was for the General Meeting Fund, and $141.72 for the Annual Meeting Fund. This report was accepted with many thanks and expressions of appreciation.

The Auditing Committee reported that the books of the Treasurer had been audited and found correct.

The President stated that the program as arranged might be changed from time to time to expedite the proceedings.

Mrs. Theodore Teimer reported as Chairman of the Society for Widows and Orphans. She asked that the County Presidents do not appoint Chairmen who are not interested in the Society. Only seven Chairmen had answered her requests for information as to what the Counties had accomplished. Her report has been filed.

She introduced Dr. Edward Ill, founder of the Society. She gave the financial status of the Society for the past year. He explained that the Society stood well, in spite of the depression. Last year they had received applications for donations which they were unable to grant because the husband had not been a member. That for the first time in fifty years the "hat had to be passed" to help this needy family. Had the husband been a member, this would not have been necessary. This report has been filed.

Report of the Entertainment Committee for the

session was read by the Chairman, Mrs. Samuel Salasin.

The Report of the Chairman of Publicity was read by the Secretary Pro Tem. because Mrs. Laird was unable to be present.

The report of the Public Health Chairman was given by Mrs. Don Epler, in which she stated that she felt that the committee had accomplished a great deal, and her report bore out this statement very clearly. She asked that we send separate reports from the Counties on Public Health and Public Relations, even though the same Chairman has charge of both.

The President stated that she had included this report at the end of her letter to the Journal, because she felt that it was such an outstanding one.

Mrs. James McGuire, Chairman of Legislation, reported on several bills which were before the Legislature and which affected the medical profession.

Mrs. A. Haines Lippincott stated that she felt that Burlington County should resent the statement made by Senator Powell in reference to the Bar Association having sunk as low as the Physicians' Association. Mrs. McDonnel answered that this matter was being taken care of by the County Society.

Report on Public Relations was made by Mrs. A. Haines Lippincott, with the remark that her report was not ready to be given to the Secretary for filing because the County reports had been so slow in coming in to her.

She announced that she had some very good literature on tuberculosis and would be glad to send this to any County writing in to her, but that if they could get it from their own counties, to do so. She asked that each County President send to her the names of the members who were serving on committees in other organizations. She felt that the Public Relations work is the most important of the Auxiliaries' activities, and that athough we have done well we should do twice as well next year.

Mrs. James Hunter, Chairman of Archives and Historian, suggested that all correspondence be free from personalities so that she might file it. Her instructions that all information should be dated, giving official names, and asked that some one volunteer to send her clippings from the Medical Journal. Mrs. Edward Clarke volunteered to do this.

Mrs. Harry Hubbard, as Chairman of Organization and Membership, gave a résumé of the proceedings of a Health Institute which she attended in Philadelphia. She thought that a Health Institute in each County would be very profitable. Invitations to this one sent to every organization in the city. Leaders in their speical groups attending and the influence of such was expected to spread widely throughout the State.

Mrs. Lippincott asked the difference between a Health Institute and a reciprocity meeting. Mrs. Casselman explained it as being more general, with more sessions, an a much more varied program.

Mrs. Lippincott asked how long the reports of chairmen might be and was informed by the President that they might be as long as one wished, and that they were to be published in the Journal.

Mrs. David B. Allman, Chairman of Credentials, reported at 11:30 a. m. that the attendance was as follows:

County	Delegates	Alternates	Members	Guests	Total
Atlantic	3	4	14	7	28
Bergen	2	1	1	4	8
Burlington	4	0	2	0	6
Camden	4	1	1	0	6
Essex	4	2	8	0	14
Gloucester	1	0	1	0	2
Hudson	4	5	1	0	10
Mercer	2	3	3	0	8
Middlesex	0	0	0	1	1
Monmouth	3	3	2	1	9
Ocean	1	0	0	0	1
Passaic	2	0	0	0	2
Somerset	3	0	0	3	6
Union	2	2	5	2	11
	35	21	38	18	112
Executive Board					18
County Presidents					8
Total					138

The President explained that we had not pushed Hygeia this year, that a Chairman had been appointed so that we might have material for those Counties who so desired.

Mrs. H. D. Corbusier, Chariman of Art and Hobby Exhibit, reported twenty-five exhibitors; that the exhibit was attended by many of the guests, and that the tea on Wednesday afternoon was well attended.

Mrs. Casselman explained that the Art and Hobby Committee was appointed at the suggestion of the former committee of the Medical Society, and was called to meeting with that committee in Trenton early in the year, at which time Dr. Campbell asked that the Auxiliary take charge of this exhibit, and that this year the old committee would work with the new.

Mrs. George Orton, Chairman of Resolutions, was asked to report on the resolution, which she had been asked to draw up, with reference to the Hay lectures which were given in Newark. Mrs. Don Epler explained that the reason for asking for this resolution was that since the Kresge store had asked the Essex County Auxiliary to send a letter of protest to the Dry Goods Association, and that although the Essex County Medical Society is taking some action, she felt that the State Auxiliary should go on record as being in favor of this letter of protest. After some discussion, such a resolution was read and accepted by the State Auxiliary. Mrs. Orton suggested that this protest be inserted in the Dry Goods Association Magazine.

The resolution was as follows:

> Be it resolved that we, the Members of the Woman's Auxiliary to the New Jersey Medical Society, protest the lectures given and the books sold by Dr. William Hay.
>
> The Woman's Auxiliary to the Essex County Medical Society suggest that a letter be sent

to the American Dry Goods Association, to be inserted in their Trade Journal, protesting Dr. Hay appearing in the Dry Good Stores throughout the Circuit.

Signed. Mrs. George Orton,
Woman's Auxiliary to the
New Jersey Medical Society

A standing vote was asked for, when thirty-eight voting members voted for it.

Mrs. H. Roy Van Ness reported for the Nominating Committee, as follows:

Mrs. Frederick Kinch—President
Mrs. George A. Rogers—President-Elect
Mrs. Thomas P. McC naghy—Treasurer
Mrs. Lancelot Ely—Recording Secretary
Mrs. A. D. Corbusier—First Vice-President
Mrs. George M. Culver—Second Vice-President
Mrs. William Freile—Third Vice-President
Mrs. Edward Clarke, Mrs. A. L. Stillwell } Directors

Motion that the nominations be closed was seconded and carried.

Mrs. Van Ness moved that the slate as a whole be adopted. This was seconded and carried.

It was moved that the Secretary cast the ballot for the slate. This was seconded and carried. The Secretary cast the ballot for the slate as presented.

The President declared the officers elected.

Mrs. Bickner in presenting Bergen County's report, stated that because of laryngitis it would be difficult for her to read clearly, and asked that Mrs. Edward Clarke be permitted to read it for her, this was granted.

Mercer County's report was given by the President, Mrs. Fell. She stated that they had appointed one member of each Hospital Group as a telephone chairman to acquaint the members of the time and place for meetings, and that this arrangement had worked so well that they had decided to use it for the coming year.

Burlington County's report was given by Mrs. G. E. McDonnel, the President. All members available are members of their County Auxiliary. They have raised $500 for a scholarship for a training course for a worthy girl.

Mrs. W. K. Campbell, as President gave the report for Monmouth County.

Hudson County was reported by its President, Mrs. Frank Nicholson.

The President then introduced the National President, Mrs. Tomlinson of Wilmington, Delaware, who told us of what this Auxiliary meant to her as National President when the National Auxiliary was to be entertained in Atlantic City in June. She commended Mrs. Salasin very highly on her work as Chairman of the Entertainment for the National Meeting, and stated that Dr. Carrington had been a marvelous help to her.

She advised us that for the first time in history, the Canadian Medical Society was meeting with the American Medical Society, and that this meeting would be the largest Medical Meeting ever held in the world.

Mrs. Casselman announced that the addresses of the President and the President-Elect would be read at the Banquet at 6.30 p. m.

The President then installed the officers for 1935 and 1936, in a very impressive ceremony in which she explained to each one a little of what it meant to be on the Executive Board.

A motion to adjourn for luncheon and reconvene at 2.30 p. m. was seconded and carried.

Luncheon was served in the Rutland Room at one o'clock during which time the President of the State Society was presented and was asked to present distinguished guests of the Medical Society. These were: Dr. Walter Biering, President of the A. M. A.; Dr. George Crile of Cleveland, and Dr. Reiseman.

Mrs. Casselman then introduced the Past Presidents of the Auxiliary: Mrs. George Orton, Mrs. James Hunter, Mrs. C. F. Adams, Mrs. Harry Hubbard and Mrs. A. Haines Lippincott, who presented the President's pin to Mrs. Casselman.

Afternoon Session

The Auxiliary reconvened in the Garden Room at 2.45 p. m.

Passaic County's report was read by the Secretary pro tem, with a letter from the County President, Mrs. W. B. Botbyl, regretting her inability to be present to give her report personally. Mrs. James North reported on the work done in Atlantic County.

Essex County was reported by the President Mrs. Don Epler. She also brought envelopes which they distributed among their members to collect pennies. They had a die made from the President's pin which they will use on their County Stationary.

A letter was read from the Secretary of Ocean County Auxiliary explaining that they had been unable to function this year.

Mrs. Lancelot Ely read her report for Somerset County.

Mrs. Pechin, President of Camden, reported for Camden County.

Cape May had no report but Mrs. H. H. Tomlin stated that there seemed to be a rejuvenation in their County and that no doubt there would be meetings held this year.

The Secretary pro tem asked that for the convenience of the incoming Secretary, all reports and letters be sent in, on regulation size paper, to facilitate filing.

A motion to accept all these reports was seconded and carried.

Mrs. Frank Nicholson announced that the project for raising money for the Physicians' Convalescent Home was not to be presented, on the advice of the Chairman of the Advisory Board, Dr. Renner, who stated that in another year or two this project would have a better chance of being put across.

Gloucester County was represented by Mrs. Chester Ulmer, who reported in the absence of Mrs. J. Harris Underwood, President.

It was moved and carried, that this report be accepted.

The President asked whether or not the Delegates to the National Convention be instructed. After discussion it was decided that this matter be taken up by the new Executive Board.

Mrs. Van Ness asked if the Resolution in regard to the Hay lectures be taken to the National Auxiliary. It was reported that the Medical Society would take up this matter.

Mrs. Tomlinson explained that the National Auxiliary Constitution and By-Laws would probably be ready to be presented at the meeting in June.

Mrs. Casselman asked that Mrs. Tomlinson explain the Article in their Constitution and By-Laws, on "Nominating Committee" and the one in regard to Widows being ineligible to elective office. She answered that the President appoints three members: one of whom is to be Chairman, and one a member of the National Board who is going out of office. Representation is to be as far as possible from different parts of the country. Concerning the ineligibility of widows holding elective office, it was felt that she would not have the same interest and contact with the Medical Organization as she had before she became a widow.

9. ANNUAL REPORT OF THE TREASURER

By Mrs. Edward W. Clarke, West Englewood

		General Fund	Annual Fund
Balance June 6, 1934		$168.65	$317.60
Receipts, General Fund:			
Dues and Arrears	$370.50		
Billheads	.75		
		371.25	
		$539.90	
Receipts, Annual Meeting Fund	$72.00		
Surplus from New Jersey Convention	25.50		
Receipts for A. M. A. Convention	72.00		
			169.50
			$487.10
Disbursements, General Fund:			
President's expenses—			
1933-1934	$ 42.48		
1934-1935	30.00		
New Jersey Federation dues	6.00		
Yardley Foundation donation	5.00		
Delegates' expenses to A. M. A.:			
Convention in 1934	50.00		
A. M. A. 1934 dues	186.00		
Printing, Postage, Telephone	45.43		
Federal Tax on Checks	.30		
		365.21	
Balance, General Fund		$174.69	
Disbursements, Annual Meeting Fund:			
Stenographer at Convention	$ 10.00		
Guest luncheons, tips, ribbons, etc.	45.38		
Flowers	17.50		
President's pin	22.50		
Advanced to Mrs. Mason for—			
a. 1935 State Convention	50.00		
b. 1935 National Convention	200.00		
			345.38
Balance, Annual Meeting Fund			$141.72

Balance, General Fund	$174.69
Balance, Annual Meeting Fund	141.72
Bank Balance May 1, 1935	$316.41

Respectfully submitted,

ALFREDA T. CLARKE, *Treasurer.*

The final report of the Committee on Credentials was as follows. 34 Delegates, 21 Alternates, 38 Members and 18 Guests—Total 129.

The President stated that her Annual Report was printed in the April Medical Journal, and that she would not take time to read it. She read a short message to the Auxiliary.

It was moved, seconded and carried that the President's report as published in the April Journal be accepted.

Mrs. Casselman then presented the gavel to the new President, Mrs. Frederick Kinch, who addressed the meeting. (Section 3.)

Motion was in order for nominations for the Nominating Committee for 1936. According to the Constitution, the outgoing President was elected Chairman: Mrs. A. J. Casselman; Mrs. William Freile, Hudson; Mrs. Chester Ulmer, Gloucester; Mrs. Harry Bowles, Union; Mrs. Edward G. Waters, Hudson.

Motion was made, seconded and carried that the meeting adjourn.

Respectfully submitted,

Clara C. Renner,
Secretary Pro tem.

REPORTS OF STANDING COMMITTEES

10. REPORT OF THE AUDITING COMMITTEE

On April twenty-fifth, 1935, the books of the Treasurer of the Woman's Auxiliary to The Medical Society of New Jersey were audited by the committee and found to be correct.

Miriam S. Teimer,
Chairman,
Betty Epler,
Committee.

11. REPORT OF THE COMMITTEE ON PUBLICITY

By Mrs. George S. Laird, Westfield

The following is a report of the publicity work that has been carried on by the Woman's Auxiliary to The Medical Society of New Jersey, and by thirteen of the fourteen organized County Auxiliaries.

Following the 1934 convention the Journal published the annual report of Mrs. Hubbard, the State President, and the annual reports of the presidents of the county auxiliaries. The Journal has been most generous in the space which it has given over to the use of the Woman's Auxiliary. The editor of the Journal has written three editorials for us, and in addition to the above, has published the following:

Four messages from our President, Mrs. Casselman.
The recording secretary's report of the Executive Board Meeting held in October.
The reports, given at the October Board Meeting by the chairmen of committees.
The reports of our delegates to the meeting of the Woman's Auxiliary to the American Medical Association in Cleveland.
The programs, as presented by Mrs. Samuel L. Salasin, for this state convention, and for the A. M. A. convention in June.
Fifty-two reports from the Publicity Chairmen of twelve of our county auxiliaries.

Your chairman has made a scrap book containing the Auxiliary reports published in the Journal, the programs, letterheads and news items received by her from the Publicity Chairmen of the counties. Atlantic, Camden and Mercer Counties are to be congratulated for the publicity work which they are carrying on in their home newspapers. This scrap book will be sent to the National Convention.

Respectfully submitted,
Caroline E. Laird,
Chairman and Reporter.

12. REPORT OF THE PUBLIC HEALTH COMMITTEE

By Mrs. Don Epler, Newark

Much progress has been made throughout the Counties this year.

As Public Health Chairman of the State, I should like to merely suggest that if the *county presidents* would work in closer contact with *their chairmen,* the reports would be more complete.

An outline was sent out to the counties in October, 1934; a letter in January, 1935, and a postcard in March, 1935.

At the request of our president, an article was sent to the Journal entitled "Timely Topics of the Public Health Committee", which appeared in the December Journal.

An outline was sent out in April with suggestions for the immunization and vaccination of the preschool child.

There is appended a report of the public health activities of the County Auxiliaries.

Respectfully submitted,
Betty Epler, Chairman.

April 29, 1935.

Atlantic County.—The Public Health Committee has been working in conjunction with the Public Relations Committee.

Concentrating on the Speakers' Bureau. They were successful in placing a speaker for the January Meeting.

President, Mrs. James North; Public Health Chairman, Mrs. Louis Rosenberg.

Bergen County combined its Public Health and Public Relations Committee.

The Auxiliary sponsored an essay contest for first year high school students. The subject was "Vaccination for Promotion of Public Health". Two cash prizes were awarded, $10 for the first and $5 for the second. The winners will be given an opportunity to broadcast their essays over station WOR in Newark.

President, Mrs. A. W. Bickner; Public Health Chairman, Mrs. S. T. Franklin.

The Auxiliary is also planning a reciprocity meeting.

The Auxiliary is doing good work, although it is a small group.

Burlington County.—The Auxiliary is too scattered to have individual committtees, but it is sponsoring the public relations program of the State Society.

The Auxiliary has study groups on "Milk". It distributed fifty-six pamphlets on "Fit for the First Day of School", fifty-six pamphlets on "What Is a Health Examination Anyway?" and sixteen copies of the set on "The Story of Life", by Dr. Thurman B. Rice.

A follow-up of the pre-school health work with a lecture on proper health examinations at a public relations tea.

President, Mrs. G. E. McDonnel; no Public Health Chairman.

Camden County.—A Speakers' Bureau has been formed and speakers supplied to Women's Clubs. Dr. T. K. Lewis is in charge. Radio health talks have been given by doctors. Dr. L. Rountree spoke on the history of medicine.

A maternal welfare clinic is being started with the assistance of the doctors.

President, Mrs. E. C. Pechin; Public Health and Public Relations, Mrs. Arthur J. Casselman.

Gloucester County.—The Auxiliary has one meeting each year devoted to Public Health work.

President, Mrs. J. H. Underwood; Public Health Chairman, Mrs. William Brewer.

Hudson County.—The Auxiliary has speakers on public health work from the Tuberculosis League,—subject, "It Pays to Keep Well". Dr. F. Vonder Leith spoke on "Germs in the Home".

A speakers' bureau is functioning.

President, Mrs. Frank Nicholson; Public Relations Chairman, Mrs. Edward Q. Waters.

Mercer County.—The Auxiliary is doing very good work through the public relations committee.

At its Reciprocity Meeting, the Auxiliary put on a health skit, "Putting Up the Sing", by Mr. Blanchard of the State Health Department.

Dr. Florence Child gave a discussion on the Welfare Department of the Trenton Health Department. Dr. Ely spoke on "The Family Doctor".

Dr. Robert Fischelis, chief chemist of the New Jersey State Department of Pharmacy, gave a résumé of the work of the Drug Control Department of New Jersey.

The Auxiliary will have another health meeting in May at the New Jersey State Hospital.

President, Mrs. A. S. Fell; Public Relations Chairman, Mrs. Leo Haggerty.

Monmouth County.—Monmouth County is well organized along public health work, and, therefore, there is very little for the Auxiliary to do along those lines; but under the leadership of Mrs. Campbell, it is carrying on, and its meetings are well attended and interesting.

President, Mrs. W. K. Campbell; Public Health Chairman, Miss Reynolds.

Passaic County.—The public health and public relations committees are combined.

There is a speakers' bureau functioning, and there has been two speakers whose subjects were "The Common Cold". They have sponsored a series of lectures on the parent-child relationship.

Some literature was given out on "Blindness and Milk".

A public health meeting was held. The Auxiliary contacted with the county Parent-Teacher Associations, the Auxiliaries of the Hospitals, the Jewish Benevolent Society, the Y. W. C. A., the St. Anthony's Guild, Women's Clubs of Paterson and Passaic, Church Societies, and the County Home Making Bureau.

President, Mrs. Burt Bothyl; Public Relations Chairman, Mrs. William Dwyer.

Somerset County.—A speakers' bureau has been formed and is functioning.

At a meeting of the Women's Club of Bernardsville in November, Mrs. D. S. Renner talked on "The Method of Admitting, Treating, and Discharging Patients at Skillman".

In December Mrs. Emma Redfern, Somerset County Tuberculosis Nurse, spoke on the care of tuberculous patients. She described in detail the "Mantoux Test".

Dr. Gladys Poole gave a talk on "Child Psychology" at the P.-T. A. meeting in April.

The public health hour has been established.

President, Mrs. Lancelot Ely; Public Health Chairman, Mrs. Josiah Meigh.

Union County.—Public Relations Meeting. A talk was given by Dr. LeRoy Wilkes on "The Doctor's Place in the Health Service of the Future".

The Auxiliary is sponsoring Hygeia by purchasing and placing subscriptions in the schools.

A reciprocity meeting was held in November. The parent-teacher associations and women's clubs of the county were invited; and a desire was expressed for more such meetings.

President, Mrs. H. H. Bowles; Public Health Chairman, Mrs. Harry Hubbard.

13. REPORT OF COMMITTEE ON HYGEIA

By Mrs. Thomas P. McConaghy, Camden

Little has been done during the past year (1934-35) regarding subscriptions to Hygeia. Although the reports received state that Hygeia is considered important and some hope to do some good work next year, only twenty-nine subscriptions were received this year in comparison to fifty-seven last year.

Respectfully submitted,
Louise McConaghy, Chairman.

14. REPORT OF THE ORGANIZING CHAIRMAN

By Mrs. Harry V. Hubbard, Plainfield

There are fourteen of the counties in the State having Auxiliaries organized and active,—leaving seven unorganized.

Letters have been written to Morris and Middlesex County Medical Societies, with the approval of the Secretary of the State Society, asking each to take action in requesting that an Auxiliary be formed, as it was brought to the attention of this committee that several people in those counties desired it.

Our program recommended for increasing membership in the auxiliaries has been—Circular letters mailed to prospects, personal and telephone calls, and communications with the President of the County Medical Society to ascertain if an organized Auxiliary is desired, and following the procedure in the hand-book.

Of ten counties reporting, the averages have run as follows: Average attendance, 38; number of meetings held, five or six; number of paid-up members, 53 average, a total of 479. Number of new members, five or six, total 50. Number of delinquents or resigned, average 22, total 198, due to several large counties dropping unpaid members from active list, but not from mailing list.

Number of deceased members, total 5.

The names of the deceased members are:

Mrs. W. Hitcroft, 510 River Street, Paterson, Passaic County.

Mrs. Emerson S. Haines, 500 Bendermere Avenue, Interlaken, Monmouth County, Feb. 21st.

Mrs. William F. Donavan, Higgins Avenue, Breille, Monmouth County, March 28th.

Mrs. J. P. Morrison, 66 Milford Avenue, Newark, Essex County.

Mrs. Charles Ripley, 39 Lincoln Park, Newark, Essex County.

Respectfully submitted,

Viola B. Hubbard.

15. REPORT OF THE CHAIRMAN OF LEGISLATION

By Mrs. James J. McGuire

The following bills are the most important ones submitted this year to the Legislature:

S-134.—The Physicians' Lien Law Bill, which replaces the old bill S-136 of 1934, was passed and signed by the Governor on March 26th.

A-28, which preserves to the Professional Boards the right to collect and expend their own funds, has been passed and was also signed by the Governor on March 26th.

A-67—68—69, for the protection of teachers and pupils in the schools from tuberculosis, have passed the Assembly and are in the Health Committee of the Senate. These bills have the support of the Legislative Committee and the Welfare Committee of the State Society.

A-238.—This is the osteopathic bill which we are vigorously opposing. This bill has so far been kept in committee, but a substitute bill has been drawn and will probably be introduced on Monday, April 29th.

A-150.—This is the chiropody bill which has passed the Assembly and is now in the Public Health Committee of the Senate. This bill allows the chiropodist to treat all local ailments of the foot and leg, and is opposed by the State Society.

S-313.—Introduced in the Senate by Senator Stout of Hudson. This bill provides permission for a man who is not a graduate of medicine but who has served in an institution as an interne for a period of years to receive a state license to practice medicine exactly the same as medical graduates. The individual for whom the bill is drawn is said to be worthy, but the precedent is undoubtedly bad. This bill has passed the Senate, and has strong support in the Assembly, but is being opposed by the State Society.

Respectfully submitted,

Blanche M. McGuire.

16. REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

By Mrs. A. Haines Lippincott, Camden

Fourteen counties out of twenty-one in the State are organized for the Woman's Auxiliary to the Medical Society of New Jersey, and thirteen have public relations Chairmen. Of these, eleven have submitted reports, Ocean and Monmouth Counties being the only counties with public relations chairmen not reporting, and Cape May County has no chairman.

Atlantic, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Passaic, Somerset and Union Counties report having held a public relations meeting to which various lay organizations were invited to hear a health program and join in social contact afterward.

Bergen County reports that such a meeting will be held in the Fall. This is one of the most important phases of the public relations work.

All the counties have had other contacts with lay organizations; Atlantic reporting health programs with women's clubs, P.-T. A.'s, Y. W. C. A. and Y. M. C. A.

Bergen County has had contacts with schools in essay contest, and other methods.

Essex County has coöperated with the Contemporary Club of Newark and has had frequent and intimate contacts with the P.-T. A.

Camden County reports many contacts with P.-T. A.'s and other lay groups.

Mercer County has coöperated with the Contemporary Club of Trenton in health programs, and has given a health play before the public relations meeting and has had requests to give the play before other groups. Somerset has had contacts with health program of P.-T. A.'s.

Burlington, Passaic and Camden Counties report using study envelopes and pamphlets on "milk and blindness" as provided by the National Auxiliary.

Burlington has also used "Why Have Health Ex-

amination" and "Fit the Child for the First Day of School".

Hudson County has used Hygeia pamphlets on sex for boys and girls, as well as literature on prevention of tuberculosis.

Camden County has used Hygeia health pamphlets, as well as a great deal of tuberculosis literature.

Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Mercer, Passaic, Somerset and Union Counties report having a Speakers' Bureau. Atlantic County has sent for its list of speakers and subjects to fifty organizations in the county. Bergen, Camden and Essex Counties have been active in recommending speakers from County Medical Societies.

Very little work has been done in the various counties in reference to the Summer round-up examinations, although some counties report progress.

Several counties have coöperated with May Day celebrations for Child Health with P.-T. A. groups. Essex has held a Health Institute.

Hudson County has been endeavoring to further interest in a Convalescent Home for Doctors which the State has sanctioned.

Passaic County has sponsored a series of lectures on the parent-child relationship.

Essex County has stressed diphtheria immunization of the pre-school child and has gotten actively behind the "Public Health Hour" and has advertised it through lay organizations.

Burlington County is giving a free scholarship to a girl from that county to the Burlington County Hospital. The Auxiliary is to pay all expenses for the girl for three years.

All projects have had the approval of the Medical Society in state and counties.

The Chairman knows of thirty-six women, members of Auxiliaries, serving on boards of lay organizations, as well as eighteen serving on hospital or welfare boards in state and county institutions. There are many others whose names I do not know.

Respectfully submitted,

Miriam Lee Early Lippincott,
Chairman.

16A. THE SPEAKERS' BUREAU

By Mrs. Theodore Teimer

The Speakers' Bureau is a joint project of the Medical Society and the Auxiliary. It is designed to promote appointments for lectures to be given to lay audiences by members of the County Medical Societies. It has functioned quietly and efficiently in ten of the County Auxiliaries.

The work of the Speakers' Bureau was described in the Annual Reports by Dr. Dan S. Renner, Chairman of the Advisory Committee (Journal, May, p. 229), and by Mrs. Casselman in her President's report (Journal, May, p. 228).

(Frequent references are made to the Bureau in the reports of the County Auxiliaries—*Editorial note.*)

17. REPORT OF THE MEMBERSHIP DRIVE FOR THE SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

By Mrs. Theodore Teimer, Newark

For three years the Woman's Auxiliary has taken an active interest in the membership drive for the Society for the Relief of Widows and Orphans of Medical Men of New Jersey.

With a somewhat discouraging report last June, I wondered if it would be possible to arouse more interest in the county chairmen. I can safely say that most of the chairmen appointed for this work have been interested, and although they may not have been successful in procuring new members from their county medical societies, I feel that they should keep the position of chairmen, and will no doubt have better results in the coming year.

The following description of the financial status of the Society was supplied by its President, Dr. Edward J. Ill:

"During the past year, we have had an increase from our investments of $1,435.57. We have had a donation from the widow of a deceased member of $417.75, which totals $1853.32. Our expenses were $25.30, and we have donated to eleven widows $1020. Because of the difficulty of investing money, we have in savings banks $9016.44. At par value our securities are valued at $47,250, which with the cash in the banks gives us a principal of $56,266.44. The only thing we are hampered by in our present income is that our mortgage certificates are paying less interest than usual. Still, as I have told you before, we have an income of $1435.57. Since I have only five minutes to talk to you, I want you to be sure to understand how well our Society stands in spite of the depression. We have always been exceedingly careful in our investments. There has never been any speculation. We have always taken the safest investments that our bankers and brokers would advise. Our municipal bonds are all good. We have seven United States Treasury bonds which yield 4 per cent. We are very anxious to get your help. We want to extend our benefit to every wdiow of all doctors in the State."

As in the past year, I have sent pamphlets, explaining the object of the society, and application blanks to each county chairman, and have urged them to again communicate with physicians of their county societies who are not members of the Society for the Relief of Widows and Orphans.

There are still two counties which have no chairman for this work. In contrast to the one county last year, four counties are represented this year in the new membership list—eleven names in all: One from Gloucester, one from Camden, three from Essex, six from Hudson.

Miriam S. Teimer,
Chairman.

18. REPORT OF THE CHAIRMAN OF THE YEAR'S PROGRAM COMMITTEE

By Mrs. Dan S. Renner, Skillman

The meeting of the Executive Board was held at Hotel Walt Whitman, Camden, October 8, 1934, the speakers being Lancelot Ely, President of The Medical Society of New Jersey; Dr. Dan S. Renner, Chairman of the Advisory Board; and Dr. Frank Overton, Editor of the State Medical Journal.

The speaker at the January meeting held at the Stacy-Trent, Trenton, was Dr. LeRoy A. Wilkes. His subject was the Speakers' Bureau.

The study program sent out by National was presented for consideration, and Burlington County used this successfully.

Respectfully submitted,

Clara C. Renner, Chairman.

REPORTS OF COUNTY AUXILIARIES

19. ATLANTIC COUNTY

Regular meetings were held once a month from October to May. A board meeting was held at my home once a month.

The County Medical Society was consulted and gave us a list of twenty-five speakers, and informed us that the list could be increased. Nine physicians addressed P.-T. A. groups, Y. M. C. A., Civic Clubs and Women's Clubs, reaching about 1200 people.

A Public Relations meeting was held. Mrs. A. J. Casselman attended.

We secured eleven new members by a membership drive.

We have tried to stimulate interest in the Widows and Orphans Society.

Dr. C. L. Andrews spoke to our group on the subject at one of our meetings.

We distributed sample copies of Hygeia at P.-T. A. meetings.

Dr. Clara Bartlett gave a review of "Full Flavour" by Doris Leslie.

A successful card party was held to raise money to buy pins for our Past Presidents. The pins were presented.

Another card party was held for charity. We contributed $70.00 to institutions in the county, and $5.00 to the training school at Vineland.

Attendance at meetings has more than doubled.

We plan to continue the work begun this year.

Respectfully submitted,

(Mrs. James) Paulina A. North.

20. BERGEN COUNTY

During the year 1934-35 the Woman's Auxiliary of the Bergen County Medical Society held monthly meetings at the various hospitals in the county.

We have had social as well as educational programs.

At our first meeting in October, Miss Ruth Enders, dramatist, presented "Mary of Scotland".

In November we heard two men from our own County Society. Dr. M. Knowles explained the workings of the State and County Societies as well as the value of the State Journal. Dr. H. B. Wilson spoke on the Emergency Relief Administration from a medical standpoint.

At our December meeting, Mr. William Richardson, managing editor of Medical Economics, spoke to us on "Current Trends in Health Insurance".

In January, we were very fortunate in having Dr. Frank Overton, Editor of the State Journal, with us. He talked about the importance of the Speakers' Bureau and the value of our getting appointments for them.

Our February meeting we turned over to a Valentine luncheon and bridge for the benefit of our Philanthropic Fund, which was a great success.

In March we heard Dr. G. M. Levitas, of Westwood, speak on "Medical Insurance for Middle Age".

At our April meeting we hope to have Col. Morris Frank from the "Seeing Eye" in Morristown talk to us of the marvelous work they are doing in training dogs for the blind.

During the year we were glad to be able to assist a needy doctor's family from our Philanthropic Fund.

Our Public Relations Committee has put on a county-wide essay contest on the subject "Vaccination to Promote Public Health", for which a first prize of $10.00 and a second prize of $5.00 is offered. The winners will be afforded the opportunity to broadcast their essays over station WOR in Newark.

We have formed, through the coöperation of the County Medical Society, a Speakers' Bureau, and while most organizations have their programs filled for the year, we have several appointments for next season.

We sent a donation to the Vineland Training School for its Research Fund.

We are planning a reciprocity meeting for April, and hope to have representatives from many lay organizations in the county present.

We have tried to increase our membership this year by sending a letter to the County Medical Society, which was read at one of their meetings, inviting all doctors to tell their wives they are members of the Auxiliary and to bring them along to our meetings. It did help, and we have a few new members this year and no resignations.

We have had one executive meeting at the home of the President, and will hold our annual luncheon and election of officers in May.

Respectfully submitted,

(Mrs. A. W.) Eleanor H. Bickner.

21. BURLINGTON COUNTY

We have a paid-up membership of 46 and an average attendance at meetings of 20, two new members having been added this year.

We hold five meetings during the year. These are in the form of luncheon meetings or teas, since we feel we must have something to interest our members who must come at a great distance to attend these meetings.

At our first meeting in September, we decided to offer a free scholarship to our School of Nursing at the County Hospital to a worthy Burlington County girl. I can report that this project has been completed, and will take effect at the next term of the Nursing School. The Auxiliary will pay the expenses of this girl for three years.

We participated in the Christmas celebration at the County Hospital, as is our annual custom.

We have sponsored the Speakers' Bureau, and have secured several speakers for lay organizations.

Our Medical Society has furnished us with a list of speakers and their topics, which we have sent on to our State President.

As part of our public relations program, we distributed to Parent-Teacher groups throughout our county fifty-six copies of literature on "The First Day of School" and fifty-six copies on "What Is a Health Examination Anyway?" Also used the pamphlet on milk very effectively for a parent education discussion group.

We have placed on the bookshelves of Parent Education Groups and in the libraries of two high schools sixteen copies of the set of booklets on the "Story of Life" by Dr. Rice. This set has met with approval and has been found to be very helpful in the study of social hygiene.

We have placed eight subscriptions to Hygeia magazine in our high schools.

At our public relations tea, which we are holding in May, we will follow up our pre-school health pamphlets with a talk on health examinations by one of our physicians.

We hope we may continue to promote the aims of our State Auxiliary and do our part in Burlington effectively.

Respectfully submitted,

(Mrs. Gerald E.) Elizabeth R. McDonnel.

22. CAMDEN COUNTY

We have had five meetings during the year.

In October, our meeting was held in the Camden Home for Friendless Children. Dr. Holsopple of the State Hospital spoke on "Childrens' Behaviour".

In the latter part of October we had our annual card party and made $175, and gave $150 of it to the Tuberculosis Society.

The January meeting was a business and social meeting held at the home of Mrs. Joseph Roberts. We also had a musicale and tea at Mrs. Roberts'. The music was by the Clarence Fuhrman Trio.

The March meeting was held at the home of Mrs. Albert Dani. It was our eighth birthday, and we had a real party. Each member brought as many pennies as she was years old. We made about fourteen dollars.

Miss Sophia Bliven spoke on Economic Security.

In April we had our annual luncheon and election of officers. Our national President, Mrs. Tomlinson, Mrs. Lawrence Jones, Dr. and Mrs. Krusen and Eleanor Morton were guests.

Eleanor Morton spoke on "Women in Public Life". Dr. Krusen gave a very interesting talk on Dickens' women. Mrs. Tomlinson talked on the A. M. A. Convention in June. Mrs. Sherk, one of our own members, sang two selections.

We have raised $100 this year for a health project and gave $5.00 to the Vineland Women's Club.

It is with regret that we mention the death of one of our oldest members, Mrs. William Westcott.

Respectfully submitted,

(Mrs. Edward) Emma L. Pechin.

23. ESSEX COUNTY

The Woman's Auxiliary to the Essex County Medical Society has a membership of 221 active members, with 18 new members since October 26, 1934. There were two resignations due to illness, and two members reinstated. It is with regret that I report one deceased member, our Mrs. Charles Ripley.

We had seven board meetings to date, with an average attendance of twenty-four members present. There were three regular Auxiliary meetings held.

The first was preceded by a luncheon, with eighty-one members present, and the following program:

Our State President, Mrs. A. J. Casselman,—"Outline of High-Lights to Be Followed During the Year".

Dr. Edgar Ill,—"Résumé of Public Health Committee of Essex County".

Mr. Michael Chanalis,—"Artistic Arrangement of Flowers".

Miss Ida Jacobs, of the Maplewood Woman's Club,—"Woman's Crusade".

The second meeting, January 28, 1935:

Dr. Earl H. Snavely,—"Relationship of the Public Hospital to the Private Practitioner".

Miss Mary Tucker,—Travelog, "Habits, Life, and Health Conditions of the Indians in the Southwest Territory". Illustrated with slides.

Tea. Welcoming of new members. Sixty members present..

March 19, members of the Auxiliary were invited guests of the Contemporary Club of Newark to hear Dr. Haven Emerson, Professor of Preventive Medicine at College of Physicians and Surgeons, on "Preventive Medicine".

March 21, the Auxiliary also had the privilege of hearing William Mather Lewis, A.B., L.L.D., President of Lafayette College, on "Education for Physical Well-Being".

The Auxiliary acted as hostesses to the doctors after the meeting, serving the refreshments.

At a reciprocity meeting on March 25, 1935, Dr. Martin E. Rehfuss, Professor of Clinical Medicine of the Jefferson Medical College, spoke on "The Question of Dietary Fadism", illustrated with slides.

The meeting was well attended by 496 persons. The Auxiliary used a tabulator, so that the record of attendance would be authentic. People came who were not admitted because of lack of room.

Work Done by the Auxiliary

A total sum of $328.41 was realized from chances on an Afghan donated by Mrs. E. D. Newman, and a supper dance given at the Essex County Country Club, for the benefit of the Auxiliary Benevolent Fund.

An appropriation of $500 was turned over to the doctors for their fund.

Envelopes were printed to collect pennies, and $13.67 were received to date for the Benevolent Fund.

A drive was put on for the immunization of preschool children at the request of the Essex County Medical Society. Full details are quoted in the Annual Report of our State President in the April Journal, page 229.

A speakers' bureau has been formed, and a list of the coöperating doctors and their subjects is ready for distribution. The Auxiliary is having 100 copies of the list printed and these will be sent out next year by our Public Relations Chairman.

Respectfully submitted,

(Mrs. Don) Betty Epler,
President.

24. GLOUCESTER COUNTY

We held an executive meeting at the home of the President, Mrs. J. Harris Underwood, on September 8th, 1934, with all of the officers present. The program for the ensuing year was discussed and then put in the hands of the Program Committee to be printed and distributed.

We had a get-together luncheon in September at the Woodbury Country Club. A goodly number attended, and a good time was had by all.

We held no meeting in October on account of the regular social session of the Medical Society. We did, however, hold a card party to promote sociability, and to make a little money for the year's expenses. This was quite a success.

Our first regular business meeting was held in November, after which we joined the doctors for refreshments and had a very enjoyable time.

The December meeting was held with nine members present. The usual business was transacted, games were played, and the women joined their husbands for refreshments.

We held a Christmas party at the home of Mrs. E. E. Downs. At that party we were addressed by Mrs. Olsen, a native of Sweden, telling us how Christmas is celebrated in Sweden. Her talk was both instructive and interesting. Mrs. Olsen was dressed in her native costume. We had carol singing, distribution of gifts and delicious refreshments.

We held a Spring meeting in April and contributed $5.00 to the Research Laboratory of the Vineland Training School, as we consider this a worthwhile cause.

Our May meeting is to be in the form of a picnic on the lawn of Mrs. C. D. Pedrick. At that meeting we will have election of officers for the next year.

We have finally succeeded in having the Medical Society form a speakers' bureau, with Dr. E. E. Downs as chairman.

Mrs. J. Harris Underwood,
President.

25. HUDSON COUNTY

The Woman's Auxiliary to the Hudson County Medical Society has 115 members.

We have a meeting each month, with an average attendance of forty members.

Our meetings have consisted of routine business, health subjects, charity,—also of efforts to establish the speakers' bureau and to carry out the program outlined by the State President. We have had interesting speakers for the latter half of each meeting. In the meantime, we have managed to make our social activities attractive with card parties, luncheons, Christmas festivities, Spring affairs; and, as a grand finale, we are looking forward to a supper dance, at which our husbands will meet our Auxiliary associates,—and learn what the Auxiliary really means.

Our charity this year has been confined to a contribution towards rent of a needy case; otherwise we have tried to save every cent for the one worthy future project, the Doctors' Home.

Our first meeting was opened with Miss Woodruff as our speaker. She is head of the Hudson County Tuberculosis League and gave a most enlightening talk and showed pictures demonstrating the travels and vitality of tuberculous germs.

In November, Dr. John Von der Leith, Bacteriologist, gave us a history of microörganisms and their relation to diagnosis, surgery, and preventive medicine.

In December, we dispensed with business and had a lovely Christmas party, with music, song, and story,—Old World movies, the Street-Singer with his accordion,—ending all with Christmas carols and an Irish jig.

January meeting was all business, with reports and plans discussed,—Widows and Orphans, Hygeia, and Speakers' Bureau stressed.

In February we were addressed by Dr. Charles Kemm Good, on the "General Care of the Skin and the Use of Cosmetics". The talk proved most interesting, judging from the questions afterwards.

March brought much information from Mr. J. C. Reiss, of Newark. He is the oldest dispensing optician in New Jersey, and stressed the point of working strictly with medical men,—of dispensing glasses on medical prescriptions only.

In April we had election of officers and a delightful book review on "The Dog of Flanders" by Mrs. John Nevin.

We have one more meeting this year, and a drive for new members, which we trust will be very successful.

(Mrs. Frank P.) Edna L. Nicholson,
President.

26. MERCER COUNTY

On October 9 an Executive Committee meeting was held at my home with all members present. Plans were made for the year, much stress being laid on a membership drive, which has been successful. A chairman was appointed for each medical group and each member has been notified by phone as to every activity we have had. This plan has worked beautifully as we have had a fine response to the invitations thus sent.

On October 22nd we had a luncheon meeting at the Y. W. C. A. with forty present. Dr. Robert Fischelis, Chief Chemist of New Jersey State Pharmacy Board, spoke on Drug Control in New Jersey, after our brief business meeting.

November 19th we held an afternoon meeting at St. Francis Hospital to fold surgical dressings. Thirty-five women were present. The Sisters served afternoon tea.

We were hostesses to the State Society in January at the Stacy-Trent. Luncheon was served and we furnished songs by Mrs. Purcell.

On February 11th we held an all-day meeting at Mercer Hospital. Surgical dressings were folded, a business meeting held and a delicious luncheon served in the Nurses' Dining Room. There were forty members present and all seemed much interested in our future plans.

On March 13th the Public Relations Committee (Mrs. D. Leo Haggerty, Chairman) will join with the Education Department of the Contemporary Club in an afternoon meeting. A health skit will be put on and members of other clubs and Parent-Teachers Associations will be invited. Tea will be served and a social hour enjoyed.

March 18th we will meet at McKinley Hospital for an all-day surgical dressing-folding meeting, with luncheon served in the Nurses' Home.

On March 29th we will have an afternoon card party at Mercer Hospital. Each member is responsible for a table and a prize; tickets fifty cents. We hope to make at least $80.00.

In May we will hold our annual meeting and complete the year's work.

In April we are to be entertained by Mrs. Harman at an organ recital in her home. Dr. Harman has just installed a pipe organ (the last word in organs) in his home, and the best organist in town, Mr. Mueller, has consented to serve at the console. We each pay fifty cents and the money goes into our treasury.

We have an active Chairman of the Speakers' Bureau who has secured names of doctors in the county who are willing to speak; also a Chairman of Widows and Orphans Relief.

(Mrs. Alton S.) Charlotte S. Fell,
President.

27. MONMOUTH COUNTY

The Woman's Auxiliary to the Monmouth County Medical Society is now meeting four times a year, in September, November, March, and May.

Our first meeting was held at Little Silver, at the Roosevelt Tea Room, September 28, 1934. This was an interesting meeting. Our State President, Mrs. A. J. Casselman, of Camden, was our honored guest and speaker. She gave a history of the Auxiliary work and a practical outline of the work which county auxiliaries are particularly fitted to do. I am sorry to report that we have not been able, thus far, to do anything with the Speakers' Bureau. The matter is still up to the County Medical Society.

Our second meeting was held on November 30, 1934, at the Garfield Grant Hotel, Long Branch. Our speaker at this meeting was Miss Margaret Gorey of the Monmouth Memorial Hospital. She gave us a delightful address on China, where she had lived for four years. She was connected with the Rockefeller Nursing Foundation and lived in one of their compounds. Beside the nursing side of her question, she told us of the vastness of the country, its climate, its language, and its money. This was a very interesting and enjoyable address.

Our third meeting was held Friday, March 29, 1935, at the Berkeley-Carteret Hotel in Asbury Park. A resolution from the Vineland Woman's Club was read and endorsed. The members also voted to contribute to the fund for continuance of the research department of the training school at Vineland.

Mrs. Lewis S. Thompson, President of the Monmouth County Organization for Social Service, has appointed Mrs. Stanley H. Nichols to represent the Auxiliary on the County Welfare Board. A fitting tribute was paid to the memory of the late Mrs. W. J. Donovan, the wife of Dr. Donovan, of Brielle, one of the Auxiliary's most esteemed and beloved members.

The Auxiliary was addressed by Dr. Charles Prout, of Asbury Park, on the importance of vaccinating against smallpox, and he strongly recommended immunization against diphtheria, especially for the pre-school child.

Dr. H. C. Graves, of Marlboro, gave a splendid address on psycho-therapy.

At all our business meetings the letters received from our State President, State Chairmen, and National Chairmen are gone over very carefully.

All our meetings this year have been preceded by a luncheon. This seems to create more interest in the work.

Our fourth meeting will be held on May 31, 1935, when we will have the election of officers and yearly reports.

The chairmen of all committees have endeavored to do all they could in the work assigned to them.

We have tried to meet all our financial obligations and still have a small balance in the treasury.

The friendly feeling which exists in our Auxiliary is responsible for our good attendance in all our meetings.

Respectfully submitted,
(Mrs. Wm. K.) Lutie H. Campbell,
President.

28. PASSAIC COUNTY

One ideal Fall day in September, Dr. Botbyl, assisted by our neighbor, Dr. Golding, cooked a beefsteak dinner for thirty-two members of this Auxiliary. It was held in our woods, and the savory odors of the steaks cooking over the charcoal fire soon attracted a crowd from the porch. The menu consisted of boiled golden bantam corn, beefsteak sandwiches, pickles, olives and celery, with more beefsteak and coffee for dessert. This party was a great social success and our treasury was $5.00 richer for it.

In October we visited the Health Centre at Public School Number 2. Here we saw how crippled, blind, deaf and otherwise handicapped children are educated and cared for.

We have endeavored to approach every lay organization in Passaic County with a view to having

a health program and a speaker furnished by the Speakers' Bureau. We have been successful in but a few cases.

On January 21 we held a luncheon meeting and card party at the Alexander Hamilton Hotel. About forty members were present.

We have placed Hygeia in the Free Public Library, St. Anthony's Guild, Y. W. C. A., and Y. M., and Y. W. H. A. for another year.

On March 18 we held our public meeting. Miss Eva Lewis Smith, psychologist, of New York, was the speaker on this occasion. This meeting proved so successful that Miss Smith has been secured for a series of lectures, the proceeds of which will be used to purchase equipment for our handicapped children.

Our year will close with luncheon followed by committee chairmen reports, and bridge. This will take place at some nearby country club.

(Mrs. Burt W.) Sadie H. Botbyl.

29. SOMERSET COUNTY

The Woman's Auxiliary to the Somerset County Medical Society has held its bi-monthly meetings regularly during the past year. Necessary business is transacted and a planned program given at each meeting.

In December Mrs. Casselman was our guest, and she presented the aims and projects of the State Auxiliary and answered our questions. We also had a book review given by one of our members.

February we had a travel talk by a member.

April we plan a musical evening to which we will invite guests. With planned programs we have had an increasing attendance and better interest in the work.

The Hygeia committee has been active, but has placed no new subscriptions.

The Widows and Orphans Society Committee has not been successful in securing new members, but we do hold this to be an active part of our interest.

The Public Relations Committee has placed one speaker, Mrs. Renner, from our Speakers' Bureau; and to this bureau Somerset County has sent five names.

We have held one card party and another is in prospect. Money has been sent to requested projects of State work, and we have continued our gift subscriptions to Hygeia.

(Mrs. Lancelot) Alice L. Ely,
County President.

30. UNION COUNTY

We hold our regular meetings on the second Wednesdays of October, December, February and April, on the same night that the County Medical Society have theirs.

Our December meeting was held at Mrs. Bowles' in Summit, with seventeen members present. After the business meeting, Dr. Barney, who spent five years as a medical missionary in Arabia, told us about her work there. Her talk was most interesting.

On February 13th we met at Mrs. Schlichters' in Elizabeth. We had our business meeting first, and then Mrs. Shirrefs gave a most interesting talk on "Flowers and Their Perfumes", illustrated with her own water color pictures.

We had our annual meeting April 10th at Mrs. Corbusier's in Plainfield, at which our election of officers took place. At this meeting we also had a talk by Mrs. Paul Morton on the "Sterilization of the Unfit".

Our Public Relations Meeting was held on November 22nd at Mrs. Bunting's in Elizabeth. The officers of the P.-T. A. and other Women's Clubs interested in health programs were invited. Dr. Wilkes, Executive Secretary of The Medical Society of New Jersey, spoke on "The Doctor's Place in the Health Service of the Future". There were about seventy-five present. Tea was served and Mrs. Hubbard told about our Speakers' Bureau and gave out sample copies of Hygeia.

On March 29th we gave a dessert bridge at the home of Mrs. Hubbard in Plainfield to raise money for the Hygeia fund. We had a very enjoyable afternoon, and also a most successful one, since we cleared sixty dollars. This money is to be used to give subscriptions to Hygeia to the schools in Union County.

In addition to our regular meetings, we have had a number of board meetings during the season.

Respectfully submitted,
(Mrs. Harry H) Elizabeth P. Bowles.

The New York Academy of Medicine

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